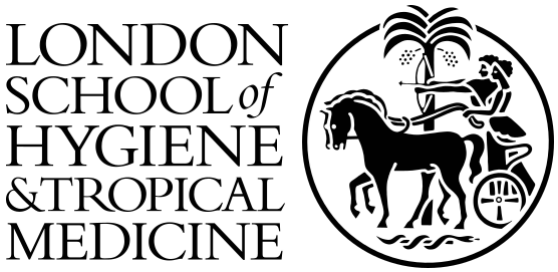

Consensus and Complacency. The Failure of Tobacco Control in Austria

Eleonore Bachinger

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While writing this report (March 2003 to July 2004), an estimated 12,750 to 19,830 Austrians died as a consequence of their smoking and an estimated 2,000 Austrians died as a consequence of the smoking of others.

ABSTRACT

Tobacco use is the leading cause of preventable death worldwide, accounting for about 9,000 to 14,000 deaths in Austria annually. Tobacco is a major health hazard not only to its users, but also to exposed non-smokers who experience a higher risk of smoking-related diseases. Yet, tobacco is also an important economic commodity seeking ever increasing markets, and opposition to regulation is very strong. The need to control its use is increasingly apparent from the growing numbers of smokers worldwide, in particular among very young people and women, the growing evidence of the effect of smoking on health of both smokers and non-smokers, and also the growing awareness of the hazards of environmental tobacco smoke.

This study examines tobacco policies in Austria, in particular in the context of European Union policies. A review of tobacco industry documents, literature on tobacco control measures in European and overseas countries, EU laws, and activities of the WHO and the EU with regard to tobacco control is followed by a description of smoking patterns in Austria, including new analyses of existing data, and an analysis of the health situation in Austria, with a focus on smoking-related diseases and mortality and a cohort analysis on lung cancer mortality. This leads to a critical analysis of tobacco control measures in Austria. The study concludes with an overall analysis of Austrian tobacco policy, seeking the reasons why so little has been done and the forces and key actors involved, and offers recommendations for further action.

The main findings are that party-political ties, economic considerations, and close relationships between the Austrian tobacco industry, the government, and leading "anti-smoking advocates", experts and scientists have hampered the development of effective tobacco control policy in Austria. Compared to many other European and overseas countries, Austria's tobacco policy lacks both political will and the implementation of effective measures to reduce smoking prevalence and to protect non-smokers from the hazards of tobacco smoke.

Doctorate in Public Health Summary Statement

The Doctorate in Public Health (DrPH) is a degree that has been designed for those who expect a career in public health practice rather than in research. The DrPH is aimed at future senior professionals and leaders in public health practice. It is comprised of three successive components: taught courses, a professional attachment affording the opportunity of reflecting on the practice of public health in a work setting, and a research project culminating in a thesis.

The teaching element of the DrPH enhanced my knowledge in specific areas, most notably in management and leadership, research methods and paradigms. The 3-month course on management and leadership was extremely valuable, as I gained much needed skills for my continuing work in governmental organisations and future career. In particular, however, it provided the basic knowledge for the production of my professional attachment. In addition to these compulsory courses on leadership and management, research methods, evidence-based policy and practice (transferable skills in public health practice), and health policy, I took a course in health economics (London School of Economics) and participated in a workshop on qualitative methods. The Qualitative Workshop improved my qualitative skills and provided both theoretical and practical knowledge for research design and methods. Subsequently, I also took courses which seemed appropriate for the initially chosen research project on life expectancy and mortality in Austria, such as Statistical Methods in Epidemiology, Ageing and Health, and Primary Health Care: Planning, Management & Evaluation.

Starting the DrPH programme after finishing an MSc in Epidemiology at the London School of Hygiene and Tropical Medicine, the elective courses I was entitled to take during my training as a DrPH student allowed me to complement the preparation I had received in the MSc programme. During the course component and later in the process of writing down the results of my research, the exchange of experiences with other research students proved an enriching and significant part of my programme.

The professional attachment was carried out at a department of the Vienna City Health Administration where I had been working as head of the health reporting unit for almost three years prior to the course. The professional attachment broadened my perspective enormously. By using the newly acquired skills in policy-making, leadership and management, combined with my training as a sociologist using organisational analysis and the qualitative technique of participant observation, I managed to gain valuable insights into the decision-making process of

large and consolidated administrative organisations, the organisational structure of the department and organisation under research, and leadership qualities. It allowed me to observe this institution from a new perspective and develop a better understanding of the powers leading to leadership and decision-making in health policy in a regional, largely party-politically driven organisation.

The third component of the DrPH is the research project. This component is designed to help students learn about the role of research in public health practice. Thus the research must be described in terms of public health relevance and the ways in which the findings of the research and improved understanding might be expected to advance policy or public health practice. The research project therefore should not only demonstrate a competence in carrying out a piece of research, but also an understanding of the wider role of research in good public health practice, and of the whole context within which research is commissioned and used.

I chose to conduct my thesis on tobacco control in Austria for several reasons. First, Austria is a country where remarkably little research has been carried out; second, tobacco control in this country is still underdeveloped; and finally, policy-making in Austria is strongly consensus-driven, based on party-political ties and personal connections, and thus seemed an interesting subject for an analysis of tobacco control policy.

The DrPH was an appropriate match for my existing skills and my newly acquired knowledge in management, leadership and academic research. Most of what I learned, however, was due to the extremely supportive and valuable collaboration with my supervisor, Martin McKee, from whom I learnt not only many technical skills in academic research, but also new perspectives in policy analysis. Although there is potential for improvement in the organisation of this programme, it will undoubtedly increase the capacity and effectiveness of public health practice.

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First and foremost, I would like to thank Martin McKee for his most professional, efficient and patient supervision of this thesis. Despite an enormous workload, he revised my endless drafts, with great commitment and often over night or while on holiday. My drafts also kept him busy on numerous long-distance flights across the Atlantic or to various destinations in Eastern Europe. Occasionally he would even make a stop-over at Vienna Airport for a meeting. During the whole programme, and particularly during a difficult time I experienced in relation to my professional attachment, he was extremely supportive and encouraging. During these last four years, I have learnt so very much from him, both scientifically and technically. The cooperation with him has also greatly improved my written language skills and his appreciation of my work has made me more confident. I know I could not have found a better supervisor and I am very grateful for his support and all his contributions to this thesis.

I am also very thankful to the members of my Advisory Committee for their contribution in different stages of the research, including valuable comments on some of the chapters of the thesis. Therefore I would like to thank Mar Pujades who helped me in drawing up the methods chapter, discussing at length the various methods with me and, with her analytical mind, when I already thought everything perfect, finding the flaws in them. I also thank her for her inestimable friendship and her moral and emotional support during all these years. Ellen Nolte I would like to thank for her valuable suggestions for the chapter on methods and the suggestions for and even provision of literature. I also thank her very much for her friendship over all these years, her readiness to help, her moral support, and for patiently listening to my ever new findings on Austria's tobacco policy landscape, giving numerous occasions for sometimes humourous comparisons to the equally regrettable situation in Germany. The third member of the Committee, Anna Gilmore, I would like to thank for her expertise on EU legislation, the discussions on tobacco industry documentaries, and her always very swift replies to my inquiries on literature.

Heinrich Gallhuber I would like to thank for his expertise in tobacco legislation during the Nazi era and his help in digging up old Reich laws. He accompanied me bravely on my excursions to Vienna coffee houses in search of possibly existing non-smoking rooms and endured with me the various reactions of waiters to our unusual request. I also thank him for his long-lasting friendship, his sympathy when things did not go as expected and his sharing my excitement about new findings, and his advice whenever I needed it.

For statistical support in calculations on Austrian lung cancer mortality rates and performance of a cohort analysis I am greatly indebted to Elfriede Urbas and Jeannette Klimont. In particular I would like to thank Elfriede Urbas for giving much thought and time to my problems. Bernhard Amanshauser was kind enough to design the maps for smoking patterns in Austria.

There are two people I am very thankful to for being able to use EndNote – as I learned, a most efficient tool to organise all my references: Mar Pujades for making me familiar with the programme and, despite occasional problems and attacks of despair, convincing me repeatedly of its benefits, and Bernd Rechel for being available in emergency cases from London or Venice even at late night hours.

There are too many to be listed here individually, but nevertheless I want to express my thanks to all my informants and all institutions and organisations which provided me with information or data material. It is, of course, the basis of this thesis. However, without wishing to minimise the help of all others, I would like to stress in particular the valuable information I received from Robert Rockenbauer, Austria's singularly committed and courageous anti-smoking advocate, and Michael Ausserwinkler, Austria's very committed former Health Minister.

For their help in correcting my English I would like to thank Rosanne Rushing and Brenda Roche who, despite their own workload, were kind enough to read some of my chapters and were also kind enough to listen repeatedly when I excitedly told them about my ever new and "interesting" findings or worried about my problems with the word count. I will miss our lovely and uplifting tea chats very much.

In this context I would also like to thank all other "Tavitonians" for their moral support, their conviviality and the exchange of experiences – in particular Pornthip Chompook, the former students' representative and now active vice-president of Taviton, and James Tibenderana, the current president, for their endeavours to make Taviton such a nice and comfortable place to stay. Pornthip I would also like to thank for her friendship and the nice time we spent together. I also thank Mercy Mugo, Andreia Santos and Shunmay Yeung as some of my room mates in the various rooms I stayed in during my visits for being such good companions; Sergio Cunha for his friendship and his inspiring stories from the Amazon; and my colleagues from the DrPH course, Catherine Murphy and Roisin Rooney, for the mutual encouragement at the various stages of the programme.

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1 INTRODUCTION

Austria (8 million inhabitants) has been a member of the European Union (EU) since 1 January 1995. Its accession has impacted positively on its policies on tobacco control yet, within the EU, Austria is still seen as the 'smoker-friendliest' country; in an assessment of achievements in the area of tobacco control and the extent to which the climate is against smoking, Austria ranked last.[1]

Tobacco poses a major hazard not only to the health of those who use it but also to those around them who, while not actively smoking themselves, have an elevated risk of developing smoking-related diseases. Yet tobacco is also an important economic commodity, produced by powerful companies with an interest in increasing sales, so opposition to regulation is very strong. Widespread acceptance of these health hazards, the dangers of environmental tobacco smoke, and the failure to reduce smoking among young people have led more governments to confront the challenge of tobacco.[2] As yet, however, the Austrian government is not among them.

Tobacco use, and in particular cigarette smoking, is now recognised as the leading preventable single cause of disease and premature death in industrialised countries. Smoking has two major health consequences. First, the smoker rapidly becomes addicted to nicotine, a substance whose addictive potential is often underestimated. Second, smoking leads to disabling and fatal diseases, such as cancers of the lung and other organs, ischaemic heart disease and other circulatory diseases, and respiratory diseases. The accumulated effects mean that half of all long-term smokers will eventually die as a result of smoking; of these, half will die before reaching retirement.[3-5] The average loss of life attributable to smoking has been calculated to be 8 years[2 5] but those who die in middle age will loose, on average, 22 years of life.[5 6] In Austria, an estimated 9,000 people[7] (according to previous estimates and estimates by Austrian officials, 12,000 to 14,000 people[8 9]) die every year from the effects of tobacco use; this equates to 25 to 38 people every day.

Although most smokers are aware of the health risks of smoking (but underestimate the extent of their relative risk), smokers tend to minimize the impact on themselves. One factor is the addictive nature of nicotine, with addiction often established in adolescence or early adulthood.[10]

In Austria, almost one quarter of the population aged 16 years and over smoke on a daily basis, most of whom have been men but now are increasingly women. The highest rate of smoking is among young male adults, aged 20 to 24 years, of whom 48% smoke.[11] However, the use of data on over 16s, the standard approach in international comparisons, obscures the increasing smoking prevalence among adolescents, particularly among girls. In an international comparison, Austrian teenagers (girls more than boys) rank very high in both alcohol consumption and cigarette smoking. The Health Behaviour of School-aged Children (HBSC) study has reported that 20% of boys and 25% of girls in Austria smoke daily.[12 13]

According to Austrian mortality statistics, cardiovascular diseases are by far the greatest single category of causes of death, accounting for more than 50% of all deaths, followed by cancers, accounting for 25% of all deaths. Both are strongly related to smoking.

Apart from the severe health effects of tobacco on smokers and the highly addictive nature of nicotine, smoking is not just an irritation to those exposed to it, but also damages the health of non-smokers, with young children, who are not in a position to protect themselves especially vulnerable.[2] Those at greatest risk of exposure to environmental tobacco smoke (ETS) include babies born to mothers who smoke, children in the presence of smoking parents, partners of heavy smokers, and people who work in smoky environments, such as hospitality workers.

Unlike the situation in some countries, the issue of passive smoking has not yet reached the policy agenda in Austria. Emerging evidence on the health consequences of passive smoking are rarely reported in the media (or if they are, in a way that is misleading, reflecting the tobacco industry's disinformation campaign) and are therefore little known by the public. Public support for smoke-free environments still reflects an acceptance of smokers' rather than non-smokers' rights. Complaining non-smokers are typically viewed as intolerant and any problem is seen as theirs rather than society's. It is not surprising, therefore, that the health effects of passive smoking and the establishment of smoke-free environments have received so little attention.

Although, admittedly, there have been changes in attitude over the last ten or twenty years, Austrians – unlike, for example, the people in Finland, Norway, or California – show little respect for non-smokers and there is no evidence of the stigmatisation of those who smoke in the presence of non-smokers (not even if they are pregnant women or children) that can be discerned elsewhere. A discussion such as that underway at present in the United Kingdom about

the health effects of passive smoking is almost unimaginable, as is the possibility of introducing "smoker-hostile" smoke-free pubs, bars/cafés and restaurants.

The consequences of smoking extend also to costs to the economy. Estimates from high-income countries suggest that smoking-related health care accounts for between 6 and 15% of all annual health care costs; inevitably the majority of the population who are non-smokers bear a significant share of these costs. Jha & Chaloupka[3] have shown how the cost of health care for smokers far exceeds that for non-smokers.[a] In Austria, the annual cost of treating the sequelae of smoking (cancer, cardiovascular diseases, chronic lung diseases) was estimated to be 15 to 20% of the total health care expenditure, amounting to €1.5 to 2 billion per year.[9 14 15]

Thus, given the evidence that smoking leads to serious health effects in smokers and non-smokers alike and both smoking itself and the resulting health effects also impose financial costs on non-smokers (through their contribution to health care costs, costs of additional cleaning, etc.), the argument that smoking is a 'private affair' and an 'individual right' can no longer be sustained.

It has been predicted that, without effective action, the burden of disease attributable to tobacco will increase dramatically over the next two decades. According to the World Health Organization's 2002 World Health Report, the immediate implementation of appropriate policies to reduce tobacco consumption is essential. Although the full benefits of action will be delayed for several years, due to the long time-lag between the onset of smoking and the occurrence of disease, these benefits would be very large and long-lasting.[2]

Measures to reduce smoking prevalence and to protect people from ETS exposure should therefore have a high priority in policy debates.[2] However, in many countries, and in particular in Austria, the impact of smoking on the health of the smoker and on the national health care system, and ultimately on the national economy, is poorly recognised and essentially ignored. There is a clear lack of political will to tackle smoking. Furthermore, the health damage due to passive smoking is still largely denied.

But not all countries have been as inactive as Austria. Many have drawn up comprehensive tobacco control plans, often including explicit goals linked to evidence-based health policies. Particularly known for their active tobacco control policies have been the American states of

[a] The argument that because smokers die earlier, lifetime health care costs may possibly be even smaller for smokers than for non-smokers, remains contentious.[3]

California and Massachusetts, Canada, Australia and New Zealand. In Europe, Norway, Finland and Sweden have been outstanding in their long-lasting and comprehensive efforts to tackle smoking. More recently, Italy has introduced smoke-free environments in restaurants and bars, making no-smoking increasingly the norm and smoking the exception, and Ireland's introduction of a smoking ban not only hit the headlines for being the first country of the EU to ban smoking in all restaurants, bars and pubs, but even stimulated some public discussion in Austria.

Despite the adverse impact of tobacco on the quality and quantity of life, the ultimately adverse impact of tobacco on the country's economy and health sector, the international experience of effectiveness of tobacco control policies, and the recognised need for co-ordinating tobacco control interventions, Austria has not yet developed any kind of tobacco control plan, or even fragments of one. So far, it has identified no goals or objectives to reduce smoking prevalence or the burden of tobacco-related disease and the measures adopted in recent decades have achieved little. Despite some half-hearted and small-scale youth campaigns, smoking prevalence among adolescents continues to rise, and services to help those who wish to quit smoking are few, often unprofessional and demand much initiative and commitment by frustrated smokers to access them.

The preceding paragraphs make the case a better understanding of the place of tobacco in Austria. This thesis examines smoking behaviour, the burden of tobacco-related disease, and implementation of tobacco control measures in Austria. It seeks to examine tobacco policies in Austria, in particular in the context of European Union policies. A qualitative methodological approach is used to develop a better understanding of Austria's tobacco control policies, to identify key actors and analyse their motivation and involvement in the decision making process. Based on the experience in other countries and findings from the literature, recommendations for more effective measures to reduce tobacco consumption will be developed, pointing the way towards a comprehensive and effective tobacco control plan that is applicable in the Austrian context.

The methods applied in this study comprise both quantitative and qualitative approaches, including secondary analysis of routine and survey data, discussions with key informants and documentary analysis. Chapter 2 describes the methods used in more detail; the structure of the remainder of the thesis is as follows:

Chapters 3, 4 and 5 review relevant literature, with Chapter 3 examining the tobacco industry in Austria, while Chapter 4 places the evidence for effectiveness of tobacco control policies within a strategic framework, and Chapter 5 examines the international context within which Austrian tobacco control takes place.

In Chapter 6 smoking patterns in Austria are described, looking at changes over time and between different groups in the population. Existing survey data are further analysed.

Chapter 7 comprises an analysis of the health situation in Austria, with a focus on the burden of smoking-related morbidity and mortality.

Chapter 8 provides a description and critical analysis of tobacco control measures in Austria.

Chapter 9 identifies key actors and analyses past and present tobacco policies in Austria.

Finally, in Chapter 10 the study concludes with an overall assessment of Austrian tobacco policy, providing recommendations for further action and implications for future research.

2 METHODS

This chapter presents the aims and objectives of the thesis, lists the main research questions examined during the work and summarises the methods used in addressing these questions. Quantitative and qualitative methods are used in answering specific aspects of the research questions and collecting different kinds of information.

2.1 Aims and objectives

The main objectives of this work were i) to describe past and current tobacco control policies in Austria, ii) to critically analyse these policies in the light of existing evidence of effectiveness, iii) to identify key actors and explain their roles in Austrian tobacco policies, and iv) to understand the opportunities and constraints faced by the Austrian government, with reference to the European Union's tobacco policy. Conclusions drawn from past and present tobacco control measures in Austria and from experiences reported from other countries should lead to an overall assessment of Austrian tobacco control policy. Secondary objectives were to describe current patterns of smoking behaviour in Austria and to determine the health status of the Austrian population with regard to smoking-related diseases. Table 2.1 lists the objectives of this thesis in more detail. The ultimate goal of the thesis was to develop recommendations to policymakers in Austria on how to best promote and support a comprehensive and effective tobacco control programme.

2.2 Research questions and methods

The main research questions in this study are to determine the effectiveness (or ineffectiveness) of Austria's tobacco control policies and to understand the powers and influential factors driving the few initiatives identified, as well as the reasons for the limited efforts invested in reducing tobacco consumption in that country. Another question was about the role of the Austrian tobacco industry in the decision making process leading to Austrian policies – for example, through the obstruction of tobacco control measures, the promotion of smoking, and the creation of a widespread pro-smoking climate in Austria, where public opinion remains very sympathetic to the convenience and rights of smokers and, ultimately, the interests of the tobacco industry. A final question concerned the identification of key factors that influence smoking behaviour in Austria.

Table 2-1 gives a summary of the study questions and the methods used to address them. Quantitative and qualitative methods were used to obtain information, including i) review of scientific journals, books and documents; ii) examination of 'grey' literature, media and conference reports; iii) data collection and qualitative analysis of information obtained through discussions with key actors and informants and through personal communication; and iv) secondary analysis of routine data and existing survey data.

Table 2-1 Objectives, research questions and methods

Objectives	Research questions	Methods
To describe the history and examine the role of Austria's tobacco industry in the promotion of smoking and pro-smoking policies	- What is the role of Austria's tobacco industry?	- Documentary analysis - Literature review - Additional information from Austria Tabak (Gallaher)
To provide a strategic framework within which to consider tobacco control measures	- What measures could possibly reduce tobacco consumption?	- Literature review - Documentary analysis
To assess the effectiveness of tobacco control measures providing evidence for successful tobacco control policies from international experience	- What is the experience of tobacco control in other countries? - Which measures have proven to be the most successful?	- Literature review - Documentary analysis
To describe the European legal framework for tobacco policy and to understand the opportunities and constraints faced by Austria	- What are the implications of EU tobacco control legislation for national tobacco control programmes?	- Literature and documentary review - Additional information by personal communication with key informants
To describe current patterns of smoking behaviour in Austria and re-analyse existing data on smoking of national and regional surveys, including international comparisons	- What are the differences in smoking behaviour with regard to time, region, age and sex? - What factors influence smoking prevalence in different groups of the population?	- Review of Austrian surveys on smoking behaviour (national and regional) - Secondary analysis and re-analysis of existing routine and survey data - Routine data review of international data -
To determine the level of smoking-related burden of disease in Austria	- What is the burden of tobacco-related disease in Austria? - What are the current trends in tobacco-related disease incidence and mortality? - Are there age- and cohort-specific differences in lung cancer mortality?	- Routine data review of health indicators (national data and international databases) - Analysis and re-analysis of national health data
To investigate and critically analyse Austrian tobacco policy by - describing and examining tobacco control measures in Austria, - identifying the most influential factors in the implementation (or non-implementation) of anti-smoking initiatives,	- What are the current and past activities to reduce smoking in Austria? What has Austria done to reduce tobacco consumption? - Are current measures and activities adequate/successful? - Why are or were certain measures or initiatives adopted and others not?	- Discussions with key informants - Additional information by personal communication with key informants (e-mail, telephone) - Literature review, documentary analysis and review of international databases - Outcome evaluation: Analysis of trends in smoking prevalence and

- assessing the effectiveness of the implemented measures, - evaluating and discussing the chosen measures or initiatives, - assessing tobacco control policy in Austria compared with other European countries that have been more successful in reducing smoking prevalence, - determining the nature and influence of hidden forces	- Why is there so little and why have the measures not been very successful? - What is the level of implementation of tobacco control policy in Austria, compared with the rest of Europe?	qualitative approach in assessing effectiveness of tobacco control measures - Review of 'grey' literature, media reports, etc.
To identify key actors in Austrian tobacco policy and examine their roles and interests	- Who are the key actors in Austrian tobacco policy? - What are their interests? - What is their role (double-role) and what have they achieved? - What are the crucial partnerships influencing related policies?	Stakeholder analysis: - Identification of key actors by snowball technique - Discussions with key actors - Additional information by discussions with key informants
To critically appraise existing evidence on the success of tobacco control initiatives and examine the reasons for that success.	- What is the potential for a comprehensive and successful tobacco control plan or programme in Austria? - What strategies need to be implemented? - Which measures and initiatives have proven to be the most successful in other countries? - Would these measures (used in other European countries) be acceptable and feasible in Austria? - What would be the legal, administrative, and cost constraints? - What would Austria need for a successful tobacco control programme?	

2.2.1 Literature and document review

A series of reviews were conducted to examine published literature, including peer reviewed and other journals, books, and relevant published and unpublished documents such as reports and industry papers, including internal documents from *Austria Tabak* and international tobacco companies. The review also included statistics on tobacco production and sales in Austria, legislation and related material on European smoking and tobacco policy, reports of smoking surveys in Austria and Europe, data on health indicators, risk factors and the burden of smoking-related disease; information on tobacco control and anti-smoking measures in Austria and other countries, and literature on policy analyses.

Sources of information and methodology used in the searches are summarised below.

Peer reviewed and other journal articles

Electronic search for peer reviewed journal articles on smoking, tobacco industry, tobacco control, environmental tobacco smoke, anti-smoking measures, smoking behaviour, smoking cessation, smoking-attributable morbidity and mortality, and EU legislation on tobacco policies was done using PubMed and the search engine Google.

Initially, the following key words were used in the searches: "smoking"; "tobacco"; "tobacco industry"; "cigarette*"; "tobacco control"; "environmental tobacco smoke" or "ETS"; "anti-smoking measures/campaigns"; "(smoking) cessation"; "nicotine"; "smoking AND mortality / morbidity / disease* / cancer / lung cancer / cardiovascular disease*"; "smoking AND children / adolescents / youth / women", "addiction"; "smoking / tobacco AND European Union"; "tobacco polic*". Subsequently, searches were conducted using the names of known authors (experts) or the titles of known studies.

For reviews on tobacco control measures and international experience, and the effectiveness of interventions on smoking prevention and smoking cessation, the Cochrane Library and the Sigel Library were searched.

The website of the *British Medical Journal*[16] was searched separately for any articles related to smoking and tobacco policies.

For tobacco control policies, in particular experiences and measures in various countries, and environmental tobacco smoke, hand searching of later issues of the journal *Tobacco Control* and the *British Medical Journal* was undertaken. Articles often led to new issues and new literature, and references were followed-up. For data on smoking prevalence and smoking behaviour in Austria, the journal *Statistische Nachrichten* of the Austrian statistics institute *Statistics Austria* (not peer reviewed) was searched, and for Austrian publications on smoking, the journals *Wiener Klinische Wochenschrift* and *Wiener Medizinische Wochenschrift.*

Selection criteria were relevance to the study and, except for issues of tobacco-related mortality and historical perspectives, publication after 1997/98.

Reports

Reports on tobacco control policies and measures were searched in websites of the following organisations: the EU Public Health[17], the European Network for Smoking Prevention[18], the World Bank[19], the World Health Organization (in particular with regard to the Tobacco Free

Initiative[20] and the Framework Convention on Tobacco Control[21]), and the Centres for Disease Control[22]. In addition, reports were identified through electronic search of Google and PubMed, using the same key words as for the search on journal articles *(as listed above)*. Names of known authors (experts) and titles of known studies were also used to retrieve reports on tobacco control policies.

Several websites of countries in which successful interventions in tobacco control have been reported were searched by using Google.

Books

For issues such as policy analysis and strategies, relevant books were found in the library of the London School of Hygiene and Tropical Medicine. In addition, references found in the literature and references provided by experts were followed up.

Other sources

Industry documents

Industry documents were searched by looking at the various on-line archives and collections of industry documents and the search engine Google, using the term "Austria Tabak" in combination with the following key words: "Philip Morris", "Health Minist*", "Government", names of several past Austrian health ministers, names of key persons linked to Austrian tobacco policies or to *Austria Tabak* retrieved in previous searches, and names of anti-smoking activists or other key actors in Austrian tobacco control policies. The websites of *Austria Tabak*[23] and the *Monopolverwaltung* (Monopoly Administration)[24] were also searched. All websites searched more intensively are listed in Section 3.2.3.

To understand the various collections (partly industry-owned), a handbook and resource guide to tobacco industry documents[25] and a paper on archives of industry documents[26] were used. Information obtained from experts and in conference presentations such as the 12th World Conference on Tobacco or Health in Helsinki (2003) and various European Public Health conferences *(see below)* was followed-up.

Selection criteria were reference to Austria and relevance to the interpretation of results of this thesis.

Laws and regulations

To categorise the European legislative framework on tobacco control (EU directives and recommendations), a framework developed by Gilmore & McKee[27] was used. In addition, the websites of the European Union[28 29] were checked. Information was also obtained from the embassy of the EU in Austria, conference reports and presentations, and published literature on general issues relating to EU legislation.

For the search on Austrian legislation the government websites on federal laws[30 31] were examined. Documents and acts provided by government officials (Federal Ministry of Health and Federal Ministry of Justice) and by the embassy of the EU in Austria were reviewed. The main Austrian laws relating to smoking comprise the Tobacco Law (1995, amended in 2001 and 2003), the Tobacco Monopoly Law (1968 and 1996), and the Employees' Protection Law (1994, amended in 1999 and 2001).

Media reports

Electronically searchable archives of the leading Austrian newspapers *Kronen Zeitung*[32], *Kurier*[33], *der Standard*[34], and *die Presse*[35] were examined. Other relevant material was obtained by hand searches and following up leads identified throughout the study. For example, additional information on Austrian tobacco policies was sought in the quarterly *NichtRaucher-Zeitung*. An extensive article in the Austrian news magazine *Profil*[36] and two TV programmes[37 38] (one recorded on video), reflecting the public debate following the implementation of enlarged health warnings on cigarette packs in October 2003 and the introduction of the Irish smoking ban in public places in March 2004, were analysed more intensively, using qualitative methods.

Conference papers

Conference presentations and papers (abstracts, reports, folders) were another important source of information, in particular with regard to industry documents, international experience, and EU legislation. The 12th World Conference on Tobacco or Health in Helsinki (2003) was especially valuable, but so were presentations at various European Public Health conferences held in Paris (2000), Brussels (2001), Dresden (2002), and Rome (2003) and Austrian conferences held by the Austrian Public Health Society (Linz 2002 and 2004).

2.2.2 Data collection

Information from key informants

Meetings were sought with key actors involved in Austrian health and tobacco control policy (former and present national policymakers, experts and consultants) and key informants on policy measures to reduce tobacco consumption (government officials, experts from NGOs and advocates for anti-smoking policies). An initial list of people and organisations known to be involved or experienced in Austrian tobacco policies was prepared and completed using a snowball technique. The final list is given in Table 2-2.

Given the diversity of topics to be addressed, a variety of formats was used to conduct the discussions: face-to-face, by telephone, or in written form by e-mail communication after providing a list of questions, often following an initial enquiry by telephone. Often it was an iterative combination of e-mail- and telephone conversations. Only the meetings with high-ranking policymakers were structured more rigidly, and shorter or longer versions of lists of questions were used according to the time made available for the meeting. Otherwise there was no fixed framework for the discussions; they were open-ended and exploratory. Data were collected between March 2003 and July 2004.

Table 2-2 summarises the main topics addressed during the meetings. General questions explored the situation in Austria, eliciting views on the pro-smoking climate in this country; measures chosen by policymakers to reduce smoking; and possible reasons or, more subtly, hidden forces (in the form of financial interests and personal relationships) that might account for the diffidence, the lack of political will, and the widely known ineffectiveness of the chosen measures. Topics addressed with national policymakers focused on reasons for the (non-) implementation of effective measures to reduce smoking; exploring the depth of political motivation to reduce smoking prevalence; opposition against proposed effective measures; and what would be seen by them as opportunities, obstacles, and threats in the implementation of a comprehensive tobacco control plan.

Table 2-2 Discussions with key actors, key informants and experts

Data collection	March 2003 to July 2004
Sought discussions	**Past and present policy makers** Two previous Health Ministers Present State Secretary of Health **Key informants and experts from government and administration** Officials/administrators from the Federal Ministry for Health and Women Federal Ministry of Finance Federal Ministry of Justice Federal Ministry for Social Security, Generations and Consumer Protection Federal Ministry for Economic Affairs and Labour, including the Regional Labour Inspectorate *(Arbeitsinspektorat)* Federal Ministry for Education, Science and Culture Administrators from local governments and administration (Vienna Hospital Association; Vienna Health Authority; provincial governments of Vienna, Styria and Vorarlberg) Officials/administrators from social and health insurance funds (Federation of Austrian Social Insurance Institutions; Vienna District Health Fund; Upper Austria District Health Fund; Vorarlberg District Health Fund) Administrators of the national statistics institute *Statistics Austria* Representatives of the embassy of the European Union in Austria **Representatives of NGOs and various associations** Austrian Cancer Society; Vienna Cancer Society Anti-smoking associations Associations dealing with health promotion or youth campaigning (Fund for a Healthy Austria; *AKS Vorsorgemedizin* in Bregenz/Vorarlberg; various associations in Dornbirn/Vorarlberg) Austrian Medical Chamber Chamber of Pharmacists Public transport (Austrian Federal Railways; Vienna Public Transport; Austrian Airlines) Hospitality industry (Chamber of Economics for Austria – Section Hospitality Trade Association; Vienna guild of hospitality industry) **Science/research and smoking cessation** Leading representatives of University institutes (Institute of Social Medicine in Vienna; Institute of Social Medicine in Graz/Styria; Institute of Addiction Research in Bregenz/Vorarlberg) Head of Nicotine Institute in Vienna Head of research group on smoking among young people and youth campaigning Administrators of centres for smoking cessation (Vienna District Health Fund; City of Vienna) **Media** Journalist of print media Journalist of TV-programme Advertising agencies **Experts and government consultants** Four experts (two of them governments consultants, all of them either leading representatives or heads of anti-smoking associations)

	Representatives from the tobacco industry *Austria Tabak* (Media Relations Office) *Monopolverwaltung GmbH* (Tobacco Monopoly Administration Ltd.) *Tobaccoland Austria* **Others** *Law historian* *Contemporary witnesses*
Topics	**General** Views on pro-smoking climate in Austria Views and experiences on Austrian tobacco policy, at present and in retrospect Views on measures chosen by policymakers to reduce smoking Possible reasons and hidden forces (in the form of financial interests and personal relationships) for the diffidence of 'engaged' advocates, the lack of political will and the widely known ineffectiveness of the chosen measures **Topics addressed at national policy makers** Reasons for the (non-)implementation of effective measures to reduce smoking; opposition to proposed measures Depth of political motivation to reduce smoking prevalence Opportunities, obstacles, and threats in the implementation of a comprehensive tobacco control plan **Specific topics addressed at experts and key informants** Activities of anti-smoking associations Smoking cessation / smokeless tobacco Youth campaigns (including financing) Anti-smoking activities on the regional level Smoke-free environments in public places (public transport, restaurants and bars, workplace, schools and hospitals) Tobacco law and law on monopoly of distribution (contents and history) Tobacco advertising and offences against tobacco law Tax gains and earmarking of tobacco taxes Smuggling Anti-smoking policies in the 1930s and 1940s **Topics addressed at tobacco industry** History of *Austria Tabak* and the Austrian tobacco monopoly Distribution and tobacco monopoly laws Implementation of larger health warnings on cigarette packs Cigarette production and sales, market shares, cigarette prices Tax gains and turnover Tar- and nicotine yields Smuggling

Personal communication

The process of information gathering was iterative. While writing up this thesis, many issues arose where it was necessary to clarify specific questions. Consequently, many individuals were contacted or re-contacted for specific information.

Similarly, for issues not published in the literature, or to confirm issues open to misunderstanding or clarification, additional information was gathered by way of e-mail or telephone conversation from *Austria Tabak*, the Monopoly Administration, *Tobaccoland Austria*, the Health Ministry, the Finance Ministry, the Education Ministry, the social insurance funds, public transport, local governments, various organisations, associations and societies on the national and local level, centres for smoking cessation, *Statistics Austria*, etc.

Another important source of information, in particular with regard to industry documents and experiences in other countries, was the communication with experts at conferences, in particular the 12th World Conference on Tobacco or Health in Helsinki (2003).

2.2.3 Data analysis

Data analysis was performed both on quantitative and qualitative data. Quantitative analysis was based on analysis of secondary data. Qualitative data were collected through discussions and personal communication; an outcome evaluation approach was applied to assess the effectiveness of youth anti-smoking campaigns.

Secondary data analysis

Quantitative analysis included secondary analysis of i) data on tobacco production and sales, profits and tax gains; ii) national health indicators and routine data provided by *Statistics Austria* and retrieved from international data bases; and iii) data from Austrian and European surveys on smoking prevalence and behaviour.

Data on tobacco production and sales, profits and tax gains

Data on Austrian tobacco production and sales, profits and tax gains were mainly provided by the Austrian tobacco company *Austria Tabak* and the Austrian tobacconists' representation *Monopolverwaltung*. In addition, data from international compilations, such as published by the National Manufacturers' Associations[39], and the WHO tobacco control database[40] were used. These figures were summarised and where appropriate presented graphically.

Health indicators, routine data

A number of general and tobacco-related national health indicators were reviewed and analysed descriptively, using routine data on life expectancy, mortality, cancer incidence, and hospital discharge statistics published regularly in the statistical yearbooks of the Austrian national sta-

tistics institute *Statistics Austria*. For international comparisons with other European countries, the international databases of OECD[41] and WHO[42] were used.

To enable time series analysis, data were re-calculated in some cases. Standardised, age-specific death rates for lung cancer in five-year age bands were re-calculated by direct standardisation for every year from 1970 to 2001, using existing data from national mortality statistics and the national cancer registry. The reference population was the European standard population[43].

In addition, analysis of lung cancer mortality for birth cohorts in 5-year bands back to 1895 was performed. Yearly standardised death rates were calculated for age groups in five-year bands, starting at age 35 and covering the period 1970 to 2000 (year of death). In a second step, the central year of birth was calculated for every age group and for every year of death between 1970 and 2000. Subsequently, the association between calculated age-specific mortality rates and birth cohorts was examined graphically.

Surveys on smoking prevalence and smoking behaviour

Prevalence and behavioural patterns of smoking by age, sex, birth cohort, region, socio-economic status, and trends over time were examined by a review of Austrian surveys both on the national and regional level.[11 44-53] Results from surveys conducted by *Statistics Austria*[11 44 48] and by the City of Vienna[46-48] were summarised for this thesis. Access to the raw data from the Vienna Health and Social Survey[54] allowed further analysis and adjustments for key determinants of smoking behaviour: age, income, employment and education. Smoking behaviour, the dependent variable, was dichotomised into current daily smokers and others. Explanatory variables used were nationality (Austrian / other), education (compulsory schooling / apprenticeship / secondary schooling / university degree), income (<€730 / €730 to <1,310 / €1,310 to <2,200 / >€2,200), and employment status (experience of unemployment over the last three years: yes or no). Crude and adjusted odds ratio and 95% confidence intervals were obtained by logistic regression using the Statistical Package for the Social Sciences (SPSS). Three models were constructed. The first looked at each variable alone. The second adjusted for age. The third adjusted for age, nationality, income, education and employment. The analyses were undertaken separately for males and females.

For a European comparison, data on smoking prevalence from Eurostat (Eurobarometer)[55] were used and described.

Analysis of information provided by key informants

The qualitative data consist of information obtained by meetings with key actors and key informants and personal communication with experts and other informants. All discussions were conducted in the German language and later translated into English.

Notes from meetings with key informants, experts, and decision makers were typed immediately following the meetings and relevant information and impressions were summarised and incorporated into the study. In one case (State Secretary of Health) permission was sought to record the discussion on tape to be transcribed later. The analysis of these discussions sought to identify the roles (or double-roles) and interests of key actors and the nature and influence of hidden forces behind the decision making process.

In particular, the results from meetings with former and present decision makers in national health policy were used i) to analyse the forces in Austrian tobacco policy; ii) to assess the political atmosphere in relation to measures to reduce tobacco consumption; and iii) to explore motivation and obstacles in creating an effective tobacco control policy.

Outcome evaluation

Outcome evaluation of effectiveness of youth campaigns allowed assessment of the effectiveness of the anti-smoking campaigns by comparing trends in smoking prevalence among youths with the adopted strategies of implementation and the chosen messages of the campaigns.

3 THE TOBACCO INDUSTRY IN AUSTRIA

3.1 Introduction

This chapter and the two that follow review the current context of Austrian tobacco control policies, highlighting the role and importance of the European Union's legislative framework and drawing on the strategic framework on tobacco control measures developed by the World Health Organization.

They pay particular attention to the binding directives developed by the European Community, directives that have been crucial factors underpinning the implementation of national tobacco control measures in countries that have otherwise resisted action and which, it is arguable, would continue to do so if not forced into action. In addition, for many European countries, among them Austria, an understanding of the nature of the debate at a European level is essential to understand the context within which reluctance to develop national tobacco control activities has persisted.[27]

As national tobacco control policies are often shaped by the position and activities of the tobacco industry in the country in question, this chapter looks more closely at the role of the Austrian tobacco company *Austria Tabak*, examining both its international and national activities, as well as the history of the company, which was a state-owned monopoly until 1997 before being privatised, step by step, and finally being bought completely by the British company Gallaher in 2001.

In addition to the review of published literature, identified mainly by using PubMed and Google, a considerable amount of information has been obtained from discussions with key informants and conference presentations, in particular at the 12th World Conference on Tobacco or Health of 2003. With regard to the tobacco industry, its meetings and its strategies, industry documents were searched for on the internet (the searched websites are listed in Section 3.2.3), but relevant material was also obtained from journals (*Tobacco Control*, *British Medical Journal*, etc.), industry and other reports and other published literature. Documents relating to the history of the Austrian tobacco company *Austria Tabak* were sought on the internet and from the company itself; documents relating to the company's activities were sought in press releases and annual company reports published on the homepage of *Austria Tabak*. In addition, information on various topics and data on production and sales were made available by the company in

response to a request. Further sources of information included specific enquiries and other communications with representatives of the *Monopolverwaltung* (Austrian tobacco monopoly administration, the representation of Austrian tobacconists) and officials of the Ministry of Health, the Ministry of Finance, the national statistics institute *Statistics Austria*, the embassy of the European Union in Austria, and other relevant informants. Information was also obtained through conference presentations, conference papers and personal communication with experts at the 12th World Conference on Tobacco or Health in Helsinki, 2003, and various European Public Health conferences.

3.2 Austria and the tobacco industry

Austria has a very long tradition of tobacco manufacturing. For more than 200 years, it was a state monopoly, member of the German *Verband der Cigarettenindustrie* (VDC) and an ally to the US companies Philip Morris and R.J. Reynolds. Even before 1989, *Austria Tabak* had strong business ties with Eastern European tobacco companies. After its partial privatisation in 1997 and in particular since 2001, when it was bought completely by the British Gallaher Group, *Austria Tabak* has been playing a key role as the home market for continental Europe and as a platform for the Eurasian region (new independent states[a] of the former Soviet Union).

However, these events taking place in Austria in the late 1990s were not unique; they were part of a global trend at that time in two ways. First, the multinationals merged into a few major conglomerates. Second, state monopolies were increasingly privatised and merged with multinationals.[4] One factor was that state tobacco monopolies, particularly in respect of tobacco production, no longer conformed to EU regulations. While in the past the strong monopolies in Europe could resist the aggressive post-war marketing strategies of U.S. tobacco companies[56], the pronounced market orientation of EU law, with its dismantling of state monopolies and the "opening of the market" now serves the interest of the global tobacco industry. It is also a striking fact that the industry seeks to transform both state-owned monopolies (for example in Europe) and private tobacco production (as, for example, in countries of the former Soviet Union) into industry-owned monopolies, either with the help of legislation and strong lobbying (as with the European Union[27], *Chapter 5; 5.2*), or by more aggressive methods, including bribing and corruption of weak and financially dependent governments (as, for example, British Ameri-

[a] The 12 New Independent States (NIS) of the former Soviet Union are: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, the Kyrgyz Republic, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

can Tobacco's actions in Uzbekistan[57]) – in both cases using the argument of "opening the market".

Following a successful legal action in Minnesota in 1998, formerly secret internal tobacco industry documents were made public, first in print and then on the internet and in depositories. The documents provide evidence of a 50-year conspiracy to resist smoking restrictions, restore smoker confidence and preserve product liability defence.[58 59] Meanwhile the publicly known tactics and strategies used by the tobacco industry to resist government regulation of its products include conducting public relations campaigns, buying scientific and other expertise to create controversy about established facts, funding political parties, hiring lobbyists to influence policy, using front groups and allied industries to oppose tobacco control measures (in particular the hospitality industry and trades unions), pre-empting strong legislation by pressing for the adoption of voluntary codes or weaker laws, and corrupting public officials.[58 60] Underlying these activities is the need to recruit a new generation of smokers and to promote the social acceptability of smoking.[61] According to David Simpson, a leading British anti-tobacco campaigner, the three major strategies of the international tobacco companies at present are directed towards deliberate misinformation of the public about the dangers of smoking; support of (ineffective) children's and youth education campaigns (thus keeping tobacco control off the political agenda and preventing further action on tobacco control by governments); and campaigns to persuade the scientific community to re-admit tobacco industry scientists into the mainstream of the scientific research community.[60 62] As shall be shown, support for (or even initiation of) government campaigns by the tobacco industry as part of their public relations strategy can be seen clearly in Austria.

The tobacco industry and its strategies to sell its products have therefore been compared with the spread of an infectious disease, where tobacco manufacturers have been described as "vectors" to transport an agent to susceptible individuals, just like a mosquito is a vector for malaria.

> "Thus, in the development of nicotine addiction and tobacco attributable disease, tobacco manufacturers produce the agent and distribute it in ways that make the product appealing.... The industry uses packaging, advertising, and promotion to reach and influence as many people as possible. The price of the product (the lower the price, the more will be sold) and the ease with which it can be obtained (from vending machines, over-the-counter displays, and sales by street vendors) are also key distribution factors. In the case of tobacco, the vector also serves to undermine public health attempts to limit use by denying for decades the health consequences of use, and resisting many health-promoting programmes and policies".[4]

However, the tobacco industry's efforts have not been exhausted simply by good marketing. For decades the "vector" has manipulated the product in ways that have made it more addictive and potentially more harmful. For example, by manipulating the pH of inhaled smoke, manufacturers have enhanced the bioavailability of nicotine to the smoker.[4 63] In addition, the general public and in particular the consumers, governments, and even vast segments of the medical and public health community have long been deceived by the use of misleading claims for "Light" cigarettes *(see later)*. Now that it becomes more and more evident to all those concerned that all strategies to develop a "safer" cigarette over the last 50 years, from ineffective filters to the claimed reduction of tar yields, have not resulted in a decrease of the smoking-related disease burden[64], a new myth of a "safe drug" is beginning to emerge – smokeless tobacco. In 2003, various arguments for and against smokeless tobacco have been presented by the medical and public health community, by the tobacco industry, and by the media.[65] In Austria, although the issue is not yet publicly discussed, current opinion leaders as well as the media appear to be in favour[66-69], thus supporting the industry's aim of introducing smokeless tobacco to an otherwise shrinking market *(see later)*. Although there seems to be no doubt that smokeless tobacco causes less harm than cigarettes, there are well-founded concerns that the public health disaster with 'light' cigarettes may be repeated in the playing down of the risks of smokeless tobacco.

3.2.1 Austria Tabak (Gallaher Group Plc): The company

Austria Tabak (or *"Österreichische Tabakregie"* or *"Austria Tabakwerke AG"*, as the company was formerly named[b]), Austria's tobacco manufacturing association, was a state-owned enterprise until 1996. It is one of the oldest companies in the tobacco business, with the tobacco monopoly having been established in 1784 by Emperor Joseph II. The company also prides itself in having the oldest tobacco research laboratory in the world, established in 1851.[71] Remaining a state-owned monopoly for manufacturing and selling tobacco products for over 200 years, *Austria Tabak* was partly privatised in 1997, following EU accession, and bought by the British tobacco group *Gallaher* in 2001 *(Appendix A)*. Altogether, the company was sold for the sum of only five times its annual profit, an issue that has attracted criticism ever since.

[b] In 1784 *Austria Tabak* was founded by Emperor Joseph II with the designation *"Österreichische Tabakregie"*. In 1939, after transformation into a 100% state-owned joint stock company, the company was renamed into *"Austria Tabakwerke Aktiengesellschaft, vorm. Österreichische Tabakregie"*. Today, after the taking over of Austria Tabak by the British company Gallaher Group Plc in 2001, the company is called *"Austria Tabak AG & Co KG – Continental Europe Division"* (AT/CED), or *"Austria Tabak Gallaher"*.[70] In this study, the company is generally referred to with the commonly used name *Austria Tabak*.

In 1997, when still half government-owned, *Austria Tabak* was the sole producer and distributor of tobacco products in Austria, controlling 59% of the domestic tobacco market (domestic brands). In addition to tobacco manufacturing, *Austria Tabak* was also the sole tobacco wholesaler in Austria, the leading tobacco wholesaler in Germany, and it also owned a wholesaling operation in Hungary.[72] *Austria Tabak's* tobacco manufacturing division produced cigarettes at three Austrian factories and one small factory in Malta (opened in 1984 and now closed down).[73] It also had built up business relationships with Japan, China, Cambodia, Taiwan and Russia, already anticipating that these countries had a potential for market growth that could offset stagnating and/or declining sales in Western Europe.[72]

Until EU accession in 1995, the Austrian market was thus characterized by a full monopoly, comprising a) cultivation, b) import and processing of tobacco, and c) import, production and distribution of tobacco products. This was according to the monopoly regulations, last laid down in the *Tabakmonopolgesetz 1968* (Tobacco Monopoly Law of 1968). Trading in tobacco products was exclusively reserved to *Austria Tabak* and those authorized by the company. The distribution by tobacconists was based on sale on commission. The history of the Tobacco Monopoly Law is described in more detail in Appendix B.[74]

As in Italy, France and Spain, a monopoly of retail sales by tobacconists still exists, its administration being subordinated to the Federal Ministry of Finance.[24] Thus, although privatised, the tobacco trade has brought large incomes for the state (whether through share of profits or taxes), which makes the state, understandably, rather reluctant to fight tobacco consumption.

Today, *Austria Tabak* belongs to Gallaher, placing this company in top spot in Austria and Sweden and making it the 4th largest cigarette manufacturer in western Europe, and the 6th largest in the world.[23] The company had chosen Vienna as the head office of the Continental Europe Division (CED) with responsibility for 35 countries in Europe, except UK and Ireland. As a trading company, *Austria Tabak* still holds important market positions in Austria, Germany and Hungary.[23]

A more detailed description of the company and its present position in the tobacco market can be found in Appendix A. Data on tobacco production and sales are summarised in Appendix C.

3.2.2 Distribution: The Monopoly Administration Ltd.

Prior to 1 January 1995, *Austria Tabak* had an 81% share of the Austrian distribution market. As already noted, since Austria's accession to the EU, *Austria Tabak* has lost its wholesale and retail trade monopolies. Any EU company or citizen is allowed to establish a wholesale distribution company for tobacco products or to apply for a retail license to trade in tobacco products in Austria. Nevertheless, the retail trade in tobacco products still requires a special license, which is person- and site-related. Other outlets or operators of cigarette vending machines need a Tobacco Order Contract *(Bestellungsvertrag)*. This special license is issued by the *Monopolverwaltung GmbH* (Monopoly Administration Ltd*)*, established by the Federal Minister of Finance in 1996, who also administers the share rights of this company. Therefore, while the retail trade monopoly still exists, it is no longer in the exclusive hands of *Austria Tabak*; indeed it does not now play any role in the retail trade. However, to fully understand the nature of this trade, one point must be borne in mind. By favouring disabled persons with a level of disability graded at least 50 percent when issuing the licence for a tobacconist shop, the retail trade monopoly is an instrument of Austria's social policy *(Appendix B)*.[75] [76]

At present (January 2004), there are about 8,200 tobacco retail outlets operating all over Austria. Of these, 3,007 are independent establishments called *'Trafik'* (special tobacconist shops dealing in tobacco products, 75% of which are operated by a beneficiary of a group representing disabled persons) and 5,201 are shops or outlets linked to other business establishments such as groceries, restaurants, and gas stations.[24] [c]

Restaurants have to buy the cigarettes from a tobacconist and must add an extra charge of at least 10% to the price.[75] A total of approximately 8,500 cigarette vending machines ("silent salesmen"[77]), half outside tobacconist shops and half in the catering business, are another important distribution outlet. *Austria Tabak* estimates 5-6% of cigarettes sold in Austria to be distributed via vending machines; the trend being said to be consistent over the last few years.[73]

[c] These are now slightly less than one year earlier. In January 2003, there were 8,292 tobacco retail outlets; 3,012 *Trafiken* and 5,280 other outlets.

3.2.3 Industry documents

Compared to the situation in Germany, where close relationships between the tobacco industry and government or other respected bodies have been discovered and written about, the search for industry documents that would compromise *Austria Tabak*, the Austrian Government or respected Austrian bodies, has yielded rather poor results, in part because much potentially relevant information is not covered by the disclosure provisions in the American court actions. However, some interesting documents could be found that give insight into the very close personal and financial relationships between *Austria Tabak*, the Austrian government, and the double-role of government consultants and so-called anti-smoking advocates, and scientists. It is a close circle of individuals who influence directly or indirectly Austria's tobacco policies and, although it is often difficult to obtain real "proof", the relationships are known to many and in some cases displayed openly *(Chapter 9)*.

Methods

Apart from the methods already mentioned in Chapter 2 and in the introduction to this chapter, this section is based on a search of the following websites:

The websites of the University of California at San Francisco, including the Legacy Tobacco Documents Library[78] and the British-American Tobacco Document Collection from the Guildford Depository (Tobacco Control Archives)[79] proved to be the most useful websites and therefore form the basis for this section. The CDC's website on Tobacco Industry Documents[80], in particular the Philip Morris sites[81], was also examined. In addition, using the keywords "Austria" or "Austria Tabak" or names of certain key actors, the following sites and industry-owned archives were explored: the Guildford Document Depository[82]; the websites of Philip Morris[83] (good results), RJ Reynolds[84] (some results), Brown & Williamson[85] (no results), Lorillard[86] (no results), The Tobacco Institute Document Site[87] (no results) and The Council for Tobacco Research Document Site[88] (no results); Gobalink (Austria News Items; some results)[89]; and TobaccoPedia[90] (no results).

For *Austria Tabak's* internal papers, documents and press releases, the company's own homepages and websites were searched.[91-94] Even though these sites are controlled by the company, some relevant pieces of information could still be found. Questions about distribution of tobacco products were examined through the homepage of the Monopoly Administration *(Monopolverwaltung)*[24].

Industry meetings in Austria

When it was a monopoly, *Austria Tabak* hardly appeared as a player on the international tobacco industry stage. Within the documents found, Austria mainly appears as a favoured conference location for meetings of senior executives – e.g. for the BATCo Chairman's Advisory Conference in May 1981, the Research Conference in August 1981 (both held in Pichlarn), or the Research Policy Group Meeting held in the Hotel Schloss Fuschl, Salzburg, in September 1988. *Austria Tabak* was praised, however, as a "most effective" host of the 8th International Scientific Tobacco Scientists' Conference of CORESTA[d] [95] in Vienna, 7-12 October 1984, and it was one of the co-sponsors for a major Vienna Conference, the Sixth World Tobacco Exhibition and Symposium, held from 22 to 25 October 1990.

However, apart from the Vienna meetings in 1984 and 1990, *Austria Tabak* participated in scientific work groups, task forces and meetings, in particular with chemists from its laboratory (Dr H. Kuhn and later his successor Dr Hubert Klus).

Detailed research on the strategies and policies pursued by the global tobacco industry have been described at length elsewhere.[59 96 97] For the purposes of the present study, examples are limited to those that involve Austria. Although the examples identified are now up to two decades old, other research suggests that the basic approaches adopted by the industry have not changed, even if their public face has.

The chosen examples are the BATCo[e]-Meetings that took place in Austria, one of them being hosted by *Austria Tabak*, and the Vienna Conference of 1990, consisting of a major exhibition and symposium, which was important in relation to developments in Eastern Europe. Apart from the Vienna Conference, the meetings were held in the 1980s; most of them involved senior executives – so permitting some deeper insights into the policies pursued. It can be assumed that the topics and strategies discussed reflect the general policies at that time, or represent the

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[d] CORESTA is the Paris-based Cooperation Centre for Scientific Research Relative to Tobacco. It is an industry-related, non-profit association with the objective of enhancing scientific co-operation for research on tobacco. In a note by H.F.D. Dymond (accompanying other documents) to Mr. B.D. Bramley from March 1992, CORESTA is described as follows: "It was founded in 1956 and since those early days it has gained an international reputation not only within the Industry but also among standard organisations, regulators and government laboratories world-wide. **It is perceived as being objective, technical and independent. It is this perception which makes CORESTA unique and very valuable for the Industry, as it is not regarded as a lobbying organisation of the tobacco industry. It is the only organisation involved with the Industry where every major Company and organisation is a member.** To date, CORESTA has approximately 190 members." According to the attached list of members, Austria is represented by *Austria Tabak* (entered in 1956), *Papierfabrik Wattens* (1976), and *Kali-Export* (1991).[95] *[Bolding by the author.]*

[e] BATCo = British American Tobacco Companies.

initiation of subsequent policies. Due to the limited space in this thesis, the contents of these meetings are described in Appendix D.

Symposiums funded and organised by the Austrian tobacco industry (such as the 1988 Vienna Passive Smoking Hearing or the 1993 Vienna Symposium on ETS) are discussed in Chapter 9.

Within the documents searched there are limited references to the Ministry of Health or individual Health Ministers. An exception are references to the 1988 Vienna Passive Smoking Hearing and the then Health Minister Franz Löschnak *(Chapter 9; Appendix S)* and comments on the "favourable environment" of Austria's Health Ministry with regard to environmental tobacco smoke[98].[f] Other references were more indirect, such as contemplation of the very high costs of the 1984 Conference in Vienna when *Austria Tabak* celebrated its 200th anniversary.[99]

The following sections deal with aspects of smoking and health and the industry's tactics in misleading the public and using politicians. This information forms the background for later chapters where tobacco control measures in Austria will be discussed.

Smoking and health

Already from the mid of the 1970s, the issue of "Smoking and Health" had become a "concern" for the industry. One of the strategies discussed in a 1975 meeting of the German Verband said:

> "A smoker-ABC must be established for employees of the industry and for the trade, giving them information on 'Smoking and Health' and with this a new self-confidence."[100]

In 1980, in a response by D. von Specht (*B.A.T–Cigaretten Fabriken*, Germany) to a previous announcement of details regarding the Chairman's Advisory Conference by Sir Patrick Sheehy (former chairman British-American Tobacco), von Specht addressed certain matters of interest that should be dealt with in this forthcoming meeting.[101] One issue of particular interest to von Specht was the experience available with regard to "training our staff about the problems of 'Smoking and Health'", indicating that health, or rather concerns about health, was seen as an up-coming "problem" at that time. Another point focused on the significance of nicotine as a stimulant and the policy that individual companies would pursue in respect to nicotine levels during product development. "We assume that too great a reduction of the nicotine figures en-

[f] Discussing the objectives of the research on environmental tobacco smoke (ETS) and the response of the tobacco industry (in particular Philip Morris) to critical epidemiological studies at the 1988 meeting in Salzburg, it was agreed that there was a need for more internal and external research. "The recent meeting in Austria, when scientists had given their views on both sides of the question to the Austrian Health Minister, showed what could be done when the environment was favourable".[98] – It is referred to the so-called Passive Smoking Hearing in May 1988, called by the then Minister of Health Franz Löschnak and sponsored, influenced and unofficially organised by the Austrian tobacco company *(Chapter 9; Appendix S)*.

tails a big risk (quitting)".[102] As history proved, however, these fears of Mr. von Specht were unfounded.

This need was fulfilled by *Austria Tabak* in a 1982 publication for its employees on arguments on the topic of smoking and health. The company followed the traditional "low delivery line". In particular, it stressed its contribution to risk reduction, which would exceed by far any other by health policy.

> "... the tobacco industry, and our firm in particular, has contributed more to rendering the problem harmless than all the campaigns and all the well-intentioned advice, all the protestations and all the anxious words. Our basic attitude, which is so simple, and which has been followed through so logically, in favour of the further development and promotion of the light cigarette, has a series of elements which are lacking in the anti-smoking action." [71]

This position is still maintained by the ex-general director, Beppo Mauhart, in public discussions *(Chapter 9; 9.3.1 and 9.3.8. Appendix V)*.

A 1975 inter-office correspondence of Philip Morris Europe SA related the internal approach to "Smoking and Health" at the Austrian company following a visit by Dr. Kuhn, the leading chemist at the then *Austria Tabakwerke*, in Neuchâtel in November 1975. The note also hinted at the activities of Philip Morris within the German *Verband der Cigarettenindustrie (VDC)*.

> "At the same time, he [Kuhn] wanted to discuss with me certain scientific aspects of "Smoking and Health" in view of the contacts we had with Dr. Kloimstein and our activities within the German Verband. ...
>
> "I was explained the internal situation at Austria Tabak where – as in most Companies – the opinion is divided as to which policy to follow in the case of "Smoking and Health". A grouping around Director General Musil prefers to follow the principle of letting sleeping dogs sleep and to react as little and as carefully as possible.
>
> "Dr. Kloimstein, who is at the deputy level below Director General Musil, coming from an aggressive marketing background, would like to attack. His approach tends to be to disregard scientific findings except for following the traditional 'low delivery' line, and he has the tendency of engaging in trying to cash in on cheap effects. The latter has sensitized unnecessarily hitherto neutral scientific quarters. If I gauged my Austrian colleague's opinion right, he feels that Dr. Kloimstein's drive ought to be harnessed and directed along a less dangerous course. ...
>
> "Needless to say, having Austria Tabak lining up with us would be of great importance in view of the effort directed towards the new German Verbandspolitik." [103]

Environmental tobacco smoke and health

In Austria, smoking in public had emerged as a "significant issue" at the end of the 1970s[104] although no official restrictions have ensued for many years. However, evidence linking passive smoking to disease and legislation to implement smoking bans are among the greatest threats to the tobacco industry. In a 1983 board of directors meeting (BAT, Imperial, Philip Morris, Reemtsma, R.J. Reynolds, and Rothmans) the industry was well aware of the "serious" issue of passive smoking.

> "Perhaps the most serious aspect is the emphasis being placed on passive smoking and smoking in the workplace. Scientific papers to defend this issue are in the pipe-line, and some activity is planned for 1984, including publication of material dealing with social costs/social values."[105]

In an advertisement entitled "A message from those who do... to those who don't", authorised by John Dollisson, a well-known figure from the Tobacco Institute in Sydney (no date, presumably about mid/end 1980s), the industry perspective on health effects of passive smoking is expressed quite straightforwardly. It represents not only the industry's opinion on this subject, but also reveals some of the "favourable" studies that provided the scientific basis for its argument. In addition, these statements have been disseminated rather successfully by the industry via the hospitality industry and the media, and one still confronts them frequently in Austria – in particular statements on "intolerance of non-smokers", being "a people problem" rather than a "governmental or medical problem", "no scientific proof" of health hazards by passive smoking, and "smokers' rights" versus "minority group" (of non-smokers who express their dislike). Dollisson also refers to the 1984 Vienna Health Conference. As these statements not only summarise more or less the industry's arguments and its lobbying on these subjects, but also characterise quite well the present situation in Austria, this document is cited in full in the following footnote.[g]

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[g] "Some smokers are annoyed by cigarette smoke. This is a reality that's been with us for a long time.

"Lately, however, many non-smokers have been led to believe that cigarette smoke in the air can actually cause disease.

"And yet there is little evidence and nothing which proves scientifically that cigarette smoke causes disease in non-smokers.

"The London Times reported findings from the Institute of Cancer Research in Surrey, England, published in this month's edition of the 'British Journal of Cancer', that 'passive smoking' for life-long non-smokers carries no significant increase in the risk of lung cancer, bronchitis or heart disease (all allegedly associated with smoking). The Institute's conclusions are based on a wealth of statistical detail from a study involving 12,000 people.

"In a study by a Vice-President of the American Cancer Society in 1981 which involved 175,000 people, it was reported that 'passive smoking' had 'very little, if any' effect on lung cancer rates among non-smokers. In the follow-up study published in 1985, no statistically significant increase in risk was reported.

"Researchers at the Harvard School of Public Health found that a non-smoker would have to spend 100 hours straight in the smokiest bar to 'absorb' the equivalence of a single filter tip cigarette.

Not surprisingly, in order to promote social acceptability of smoking, the industry's principal tactics include denial of scientific evidence and the funding of industry-friendly research to provoke controversy.[100] They also include the manipulation of public opinion, often with the participation of the hospitality industry.[61] The recent industry-funded study by Enstrom and Kabat[107], published in the British Medical Journal only a few days before voting on the World Health Organisation's Framework Convention on Tobacco Control in May 2003, is one example of this.[108]

Enemies and allies of the tobacco industry

In Austria, it is not quite clear who the real enemies or allies are. As already indicated above, the situation is characterised by a close circle of personally related and/or financially susceptible individuals, some of whom seemingly operate on both sides. In addition, as there is absolutely no interest from the state in any effective measures to reduce smoking[h], the linkage between the former state monopoly *Austria Tabak* and the government being traditionally very strong. The prolonged lobbying by Austria's tobacco industry of the hospitality industry, trade unions, the media, and the sports business (sponsoring of clubs and events) has been most effective so that its allies are not only strong and organised, but their number is clearly overwhelming the few, mostly rather diffident individuals engaged in anti-smoking activities *(Chapter 9)*. Similarly, it has not always been clear on which side the various Austrian health ministers and decision makers stand or stood. Apart from two engaged ministers, the motivation to implement anti-smoking measures has been very poor so far. This seems to confirm the finding of the previously cited John Dollisson, when he presented his insight at the 1990 Infotab Conference in Paris that politicians have never been a real threat or enemy to the industry. They were classified by him as being "mostly weather cocks who rotate to the whims of fashion and

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"Major reviews on 'passive smoking' over the last few years have concluded that 'passive smoking' cannot be shown to be a health risk. The weight of evidence is summed up in the remarks at the conclusion of the 1984 Vienna Health Conference which was held in co-operation with the World Health Organisation: 'should law makers wish to take legislative measures with regard to passive smoking, they will, for the present, not be able to base their efforts on a demonstrated health hazard from passive smoking.'

"Often our own concerns about health can take an unproven claim and magnify it out of all proportion; so what begins as a misconception turns into a frightening myth.

"Alright, cigarette smoke may be annoying to some non-smokers, but how shall we deal with these problems? Confrontation? Segregation? Legislation? – No.

"We think annoyance is neither a governmental nor a medical problem. It's a people problem. Smokers can help by being more considerate and responsible. Non-smokers can help by being more tolerant. And both groups can help by showing more respect for each others rights and feelings.

"Don't let intolerant minority pressure groups use you to create divisions between Austr(al)ians." [106] *[Bold sections as in the original text; brackets in the last word added by the author.]*

h Just to mention the various tax gains from VAT, income taxes, or import purchases taxes for tobacco products from outside the EU, or the profits from the state's shares in the Monopoly Administration Ltd.

perceived advantage".[109] The real enemy was considered to be "much more formidable". "Our enemy is composed of a vanguard of clever, able and formidably persistent [anti-smoking] activists who have, after many years of relentless permeation, increasingly taken over the commanding heights of the health and other government bureaucracies of the world. ... Our enemies are assisted in their 'long march through the institutions' by their ideological peers in the media, and in the universities".[109] Unfortunately, however, the rather flattering description of the "much more formidable" enemy and his assistants does not apply to the situation in Austria (except for one notable, but powerless individual).

The recruitment of scientists to justify the position of the tobacco industry or to vilify opponents has been common for many years. John Dollisson praised, for example, Professor Peter Berger, "one of the most distinguished sociologists in America", whom he characterised as "the shrewdest observer of our condition and the sharpest analyst of our opponents" – in this case the anti-smoking activists. As well as classifying anti-smoking activists as "people who desire power, prestige, or income from the anti-smoking campaign" and the enthusiasts among them "think of anti-smoking in terms of a crusade", Berger points at the World Health Organisation as the major vehicle for the internationalisation of the anti-smoking phenomenon. As quoted by Dollisson: "The injection of the anti-smoking cause into the UN universe of discourse has had ideological as well as organizational ramifications. The UN is, above all, an organization of Third World governments. Logically enough, the anti-smoking cause has here become entangled with other strands of Third World ideology, notably hostility to multinational corporations. The tobacco industry has thus become targeted as yet another nefarious manifestation of multinational capitalism".[109] Berger also noted that the anti-smoking movement is class specific. While smokers are increasingly drawn from the lower income groups, the anti-smoking movement is largely upper middle class in its composition.

Concluding his speech at the Infotab-Conference, Dollisson reminds the audience of his "ten commandments" with regard to the industry's tactics, including that coalitions are essential and that one has to work on one's allies, maintain relations and "not leave everything to the last minute". He also stresses the point that "results are more important than claiming authorship", i.e. the involvement of the industry should not be openly visible, and argued that the industry defence against "the antis" should be put above petty corporate differences. Finally, Dollisson stated that it was time to complement "private affairs campaigning" with a major "public affairs campaign".[109]

Advertisement and advertising bans

In the 1980s, several reports published by the tobacco industry attempted to prove the ineffectiveness of tobacco advertising directed at children and youth. These included, for example, the industry-sponsored study by The Children's Research Unit in London on juvenile smoking initiation and advertising[110] or the report of the UK Tobacco Manufacturers' Association on children, smoking and advertising[111]. The introduction of the latter begins:

> "Anti-smoking campaigns frequently invoke the emotive argument that tobacco advertising encourages children to start smoking. In fact, however, there is no convincing evidence that such advertising causes **anyone** – adult or child, male or female – to start smoking, or to smoke more.
>
> "In the UK, companies advertise tobacco products to increase market share among existing, adult smokers. Such advertising encourages those smokers either to switch to, or to remain loyal to the brand being advertised.
>
> **"However, such advertising cannot – and does not – increase the size of the total market."** [111] *[Bold in original text]*

This report expands on various "frequently asked questions" and justifies (partly referring to the results of the previously mentioned and other industry-sponsored reports) why an advertising ban would not stop young people from smoking. Interestingly, some of the statements in this document can still be found, for example, in the contemporary self-portrayal by Gallaher *(Appendix E)*.

An *Austria Tabak* publication from 1982 to provide its employees with "balanced information", justifies the necessity of advertising in particular with the development and marketing of "light" (and "safer") cigarettes *(see below)* and the company's responsibility for risk reduction.

> "Development of new products *[light cigarettes]* makes sense only when they can be made acceptable on the market. For this purpose, corresponding advertising possibilities are necessary. The firm must therefore oppose limitations on advertising, must exploit all legitimate possibilities of getting round existing limitations on advertising, and must campaign in public for the further extension of advertising possibilities, taking into account the necessities of the health policy aspect."[71]

In contrast to official industry claims of the absolute ineffectiveness of advertising, John Dollisson emphasised in his speech at the Infotab-Conference in Paris 1990 the importance of resistance to advertising bans. "In the case of advertising bans, the consequential effects could be enormous, even possibly denying us whatever political and media clout we still have. The power of advertising is so great, we will probably only realize the scale of its influence after we lose our freedoms. The loss of the support of the media will further accelerate the decline of the industry's and smoker's social acceptability"[109] – as already mentioned, one of the greatest threats to the tobacco industry.

The myth of "light" cigarettes

Cigarette manufacturers have employed several tactics to encourage consumers to perceive filtered and low machine yield brands as safer than other brands. These tactics include using cosmetic (that is, ineffective) filters, loosening filters over time, medicinal menthol, high tech imagery, virtuous brand names and descriptors, adding a virtuous variant to a brand's product line, and generating misleading data on tar and nicotine yields. Earlier filters on cigarettes turned out to be not only completely ineffective, but to produce even higher delivery of tar and nicotine compared to unfiltered cigarettes. These reversals even occurred within brand families.[112] In addition, machine-measured yields (those stated on the side of each cigarette pack) do not reflect the smoker's real tar exposure. For example, smokers tend to block the ventilation holes designed by the industry to reduce machine (but not actual) yields.[27 113 114]

While cigarette design has been changing over the last 50 years, first by the introduction of various filters and then by substantially lowering machine-measured tar and nicotine yields, they have not contributed importantly to any meaningful reduction in the disease burden caused by smoking. Thun reported in 1997 that the relative risks among smokers of all the major smoking-related diseases are higher today than they were in the 1950s and 1960s. According to Shopland, this is quite remarkable, considering that tar and nicotine levels are supposedly 60 percent lower today compared to 40 years ago.[115] Although claims are made for meaningful reductions, there are no standards as yet. As Jack Henningfield pointed out on the 12th World Conference on Tobacco or Health in Helsinki 2003, cigarettes are more addictive than is necessary to retain smokers. In summary, tobacco delivered nicotine is in a form that is highly toxic, addictive, and delivered explosively fast in a chemical cocktail which increases dose and speed, with additives reducing sensory barriers.[116]

A recent study by Pollay & Dewhirst[112] shows that advertisements of filtered and low tar cigarettes were intended to reassure smokers concerned about the health risks of smoking, and to present use of these products as an alternative to quitting. This approach was first developed in the early 1950s, when scientific and popular articles presented lung cancer research findings and consumers heard allegations about the possibility of fatal health risks. Tobacco companies reacted to this "health scare" with filtered products, accompanied by advertisements with explicit health assertions. The first Surgeon General's report on smoking in 1964, however, reawakened public concerns about the potential health consequences of smoking. In order to reduce these consumer concerns, the tobacco industry reacted quickly by offering an attractive alternative to quitting for many smokers – by switching to a lower yield cigarette. Light and

Ultra Light cigarettes were first introduced in the 1950s and 1960s[i], followed by aggressive marketing that sought to diminish health concerns and to reassure smokers that they could smoke with less risk. The majority of the current generation of low yield products were first launched in the mid 1970s. By the end of that decade, 50 percent of the cigarette brands on the market were officially classified as "low tar" according to the FTC method[j].[115] In Austria, compared to many other European countries, 'light' cigarettes were marketed relatively early (1970s).

Many "Light" smokers still believe that smoking these cigarettes causes less harm to health.[118] According to a study by Shiffman *et al.*[119], this is partly due to their experience that 'light' cigarettes are less harsh and the belief that these cigarettes deliver less tar. Considering the fact that smokers, addicted to nicotine and desirous to get their required fix, compensate for reduced nicotine yields by smoking more intensively, i.e. inhaling more deeply and more often (a fact that has been known to the industry since the mid 1970s[120] – *see below*), it is not surprising then that the smoker's actual tar exposure may be as high, or even higher as when smoking regular brands.[27] It was recognised that a smoker's level of exposure is not based on the type of cigarette and the supposed amount of tar, nicotine, and carbon monoxide it allegedly contained, but on the smoker's own behaviour: the number and size of puffs taken on each cigarette, the depth of inhalation, the blocking of filter vents, the number of smoked cigarettes, etc.[64 113 114]

As was demonstrated in an article by William Farone, the former director of applied research of Philip Morris USA, in a recent issue of *Tobacco Control*, the cigarette industry has managed to avoid any real harm reduction in their products over the years. The differences in tar levels between 'Lights' and 'Low Tar' versions of cigarettes is minimal, and also the use of descriptors such as 'Lights' and 'Ultra Lights' creates more confusion than giving an informative description of composition. Farone proves that, while regular brands with a low tar level were already on the market, versions labelled 'Lights' were introduced to the market with equal or much higher tar levels.[121] Similar results were reported in a recent study by Pollay & Dewhurst on the illusion of harm reduction in cigarettes in the 1990s.[122 123]

Although numerous studies began document publicly how smokers who switched from higher tar and nicotine products to lower yield brands experienced exposure levels that were totally

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i Manipulations of nicotine yields in cigarettes were already reported from Germany from the mid-1930s.[117]

j The FTC method was developed by the Federal Trade Commission (FTC) in the late 1960s, to test cigarettes on a routine basis for tar and nicotine levels. In June 1994, the accuracy and appropriateness of the FTC test was questioned and found "broke". However, this method is still used today.[113]

inconsistent with the published FTC-determined tar and nicotine values[115], the industry had earlier arrived at the same conclusion, leading to the massive marketing strategy for their new 'Light' products. The industry was also conscious of its endangered position. At the Research Conference in Pichlarn in August 1981, this fear was expressed quite clearly:

> "It is felt that the time is close when Government agencies worldwide will take more notice of compensation – and of the scale of the differences, for a given commercial product, between smoking machine numbers and the dose of smoke actually obtained by smokers".[124]

There are thus sound grounds for concern that the designation of 'light' cigarettes may undermine cessation as they are promoted as a reasonable (and easier) alternative to quitting. Over the past 30 years, as Canova and colleagues point out,

> "increasing numbers of smokers have switched to low tar cigarettes brands, in the hopes of reducing the harm from smoking. We now know, however, that the public health benefit of low tar cigarettes is likely negligible, or actually negative, because the evidence indicates that (1) the health risks of smoking have increased, not decreased.... and (2) it appears that more people are smoking than would be the case were these products not on the market".[64]

This can be seen in the Austrian 1997 survey on smoking habits where a change of brand and the switching to lighter cigarettes are seen by many people as a means to reduce their tobacco consumption or to avoid giving up smoking completely. One in four interviewees reported that he/she has changed brands between 1992 and 1997; women more often than men and individuals in urban areas more often than in rural parts of Austria *(Chapter 6; Appendix K)*. Not surprisingly, therefore, according to the study of Shiffman and colleagues, "Light" smokers showed a greater interest in quitting than Ultra Light Smokers. In addition, strong promotion of "light" cigarettes seeks to draw more female smokers into the market.[119 125]

This change in smoking behaviour is already apparent in epidemiological trends. According to Christian Vutuc from the Vienna University Cancer Research Institute *(Chapter 9; 9.3.3 and Appendix U)*, a clear shift in the localisation of lung cancer from central to peripheral foci can be observed over recent decades. While in the 1970s, 11% of carcinomas in Austria were peripheral, in 1990, it was already 28%. Today, this figure amounts to 57%.[126] A recently published study by Harris and colleagues on the risk of lung cancer among smokers of cigarettes with different tar levels concluded that risk is similar in people who smoke medium tar cigarettes (15-21mg), low tar cigarettes (8-14mg), or very low tar cigarettes ($\leq$7mg).[127 k]

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k In Austria, these kind of studies have been carried out by Kunze and Vutuc since the late 1970s. At least some of them were financed by the Austrian and German tobacco industry *(Chapter 9; 9.3.3 and Appendix U)*. However, the results are still treated as something 'new'.[128]

The increased market share of new "Light" brands and the realisation that these cigarettes do not reduce risk have led to increased concerns within the medical and public health community. The Surgeon General's report of 1981, therefore, strongly cautioned smokers not to increase their smoking or change their behaviour in other ways. The report ended with the advice that there is no safe cigarette. The only way to reduce one's risk from smoking completely was to quit or not to begin smoking. As Shopland points out, that advice is as true today as it was 20 years ago.

> "Although the public may believe that the major change in terms of cigarette design over the past 40 years has been the reduction of risk posed by low tar filter cigarettes, cigarettes today are just as deadly as they were back in the 1950s, and perhaps even worse".[115]

Therefore, as stated by Thun & Burns, tobacco control policies should not allow changes in cigarette design to subvert or distract from interventions proven to reduce the prevalence, intensity, and duration of smoking[129], and the medical and public health community should no longer recommend that smokers switch to lower yield cigarette brands as a means of reducing their future disease risks.[114 115]

At present, activities similar to the marketing of 'Light' cigarettes can be observed with smokeless tobacco, which is praised as a 'healthier' option to cigarettes. In the US, every three or four months new tobacco products are launched on the market, with new claims (e.g. nicotine water, nicotine lollipops, nicotine wafers, etc.), in addition to the promotion for smokeless tobacco (snuff).[130] As in other countries, hidden advertising for this product is now starting in Austria, pointing to the long tradition of *snus* (moist snuff) and the low lung cancer rate among men in Sweden. Michael Kunze, the leading smoking cessation expert in Austria, and Karl Fagerström from Sweden are pushing for a "controlled legalisation" of *snus* in Europe, allegedly with a view to it becoming an alternative for heavy smokers *(Chapter 9; 9.3.3 and Appendix U)*. Scientific 'proof" of the safety of this "largely harmless" and "mild" nicotine drug can also be found in a recent corporate article by Ernest Groman, head of the Vienna Nicotine Institute and colleague (and son-in-law) of Michael Kunze, and Karl Fagerström[66]. The results of this study and the product itself were praised (or advertised) in two *(sic)* newspaper articles in the *Wiener Zeitung* of 31 May 2003.[67 68] Of course, nothing was mentioned about any risks from this "replacement drug". Yet in the end, as the majority of public health advocates have noted, advertising this product as a 'safer' drug might easily lead to the same results as the public health disaster with 'Light' cigarettes, preventing smokers from quitting and resulting in an increase of tobacco consumers. In any case, the issue of its use as a substitute for cigarettes raises scientific and ethical questions, as Lynn Kozlowski formidably demonstrated in her recent article.[65] Per-

haps the most that can be said is that consumers of smokeless tobacco at least are not posing a risk to others.

It seems that the once freely expressed opinion by the tobacco industry that people have to die from something and that "cancer is an essential ingredient of life" has not been really overcome as yet, although since the publication of many formerly secret industry documents, industry staff are certainly more careful with these kinds of statements. As cited in Kozlowski, one can read in a proposal from 1978, prepared for the UK's Tobacco Advisory Council by the UK firm *Campbell Johnson Ltd*:

> "2.7. This last point, a brutally realistic one, implies that, with a general lengthening of the expectation of life we really need something for people to die of. In substitution for the effects of war, poverty and starvation, cancer, as the disease of the rich, developed countries, may have some predestined part to play. The argument is obviously not one that the tobacco industry could use publicly. But its weight, as a psychological factor in perpetuating people's taste for smoking as an enjoyable if risky habit, should not be under-estimated.
>
> 2.8. .... in its controlled and positive aspects, cancer is an essential ingredient of life without which the cells of the human body would be unable to renew themselves".[65]

3.2.4 Self-portrayal of Austria Tabak (Gallaher)

Although definitely meant for the public and therefore a 'lighter' version of the industry's position, the present self-portrayal of Gallaher still reflects the same tradition and the same justification with regard to advertising and other smoking-related topics. However, the industry is now aware of the higher sensitivity on the part of governments and the public with regard to smoking and smoking-related problems. The concept of corporate social responsibility has been taken up, at least in rhetorical terms. So, in its overall concept, Gallaher sees itself as a "responsibly behaving, good corporate citizen", boasting of its success and its strong position on the stock market.

Smokers are described as "those people who choose to smoke", i.e. as "informed adult smokers", and the classification of smoking not being an addiction but rather a "habit", although possibly a "very strong habit". Environmental tobacco smoke is not considered as a health hazard to others; at worst, it might be "a source of considerable annoyance to non-smokers".[131] As the issue of environmental tobacco smoke is closely related with programmes to tackle the harmful effects of tobacco it will be dealt with later in Chapter 4, Section 4.3.3. A more detailed view of the company's homepage is presented in Appendix E.

4 TOWARDS A STRATEGIC FRAMEWORK FOR ACTION: TOBACCO CONTROL MEASURES

4.1 Introduction

By looking at the various tobacco control interventions[a] reported in the literature and employed in other countries it is possible to examine what has been done in Austria in the field of tobacco control and what is still to be done. However, while the situation in Austria will be examined more closely in Chapter 8 and 9, this chapter will primarily look at the international evidence and experience, thus providing the basis for the later analysis.

Several measures to reduce tobacco consumption have been recommended by various sources, based on the experience of many countries. Most important is the insight that it is not the implementation of a single measure that accounts for the success of a tobacco control programme, but the simultaneous implementation of a whole package of measures, which should complement and reinforce each other. Thus, a comprehensive, sustainable, adequately funded programme, supported by decision makers, stakeholders such as cancer societies or anti-smoking groups, committed individuals, health professionals, service providers, and the public, has proven to be very effective in reducing tobacco consumption, smoking prevalence, and smoking-related disease and mortality.

The strategic framework in this chapter is based on the WHO-publication European Strategy for Tobacco Control (ESTC)[132], which sets out strategic directions for action. Examples of successful tobacco control policies in other countries were found via the internet (using Google) and by hand search of later issues of some journals, in particular *Tobacco Control* and the *British Medical Journal*. The methods used were described in more detail in Chapter 2.

The industry perspective is represented by excerpts from literature on Gallaher's position on the World Health Organization's Framework Convention on Tobacco Control.[133] Other influential factors known to deter key actors from the implementation of a comprehensive and effective tobacco control plan – such as the promise of enormous financial gains for both the tobacco industry and the state – are also discussed. Experiences from other (particularly European) countries, which could serve as models of good practice for Austria, have been reviewed and described.

4.2 Measures to reduce the demand for and supply of tobacco products

The World Health Organisation distinguishes demand-side and supply-side measures. Measures to reduce the demand for tobacco products include price and taxation; prevention of exposure to environmental tobacco smoke (passive smoking); control of advertising, promotion and sponsorship; information, training and public awareness; smoking cessation; product control and consumer information. Measures to reduce the supply of tobacco products involve reduction of illicit trade; availability to young people; and tobacco subsidies. The latter, however, are in general less effective, while demand-side measures work well, in particular when implemented simultaneously. However, it has also been recognised that

> "Member States and the European Community, when applicable, will have to adopt different sets of measures, based on their concrete needs, resources, and the stage they have reached with their tobacco control policy, and according to a realistic time frame. In the meantime ... national tobacco control policies should be comprehensive enough to cover all major aspects of the demand for and supply of tobacco products".[132]

Despite the fact that cigarette smoking damages human health, leading to chronic disease and premature death, many governments (including Austria and Germany) have avoided taking action to control smoking because of concern about potential economic harm, but also due to the strong, long-term influence of the tobacco industry in the form of very close and friendly relationships between government and industry and most of all the latter's effective lobbying. Yet while it cannot be said that Austria has been inactive in enacting public health measures, what is striking is that, from the range of possible interventions, most measures chosen have been from the category "less/not effective" rather than "very effective" or even "likely to be effective", as presented by Heather Selin[134] in the following overview (Box 4-1) of the effectiveness of key measures *(see also Section 4.3.4)*.

[a] According to the definition of the WHO intervention means "any health action – any promotive, preventive, curative or rehabilitative activity where the primary intent is to improve health".[2]

Box 4-1 Examples of evidence-based measures in tobacco control that have proven to be very effective or less effective

Very effective measures	Less effective measures
• Significant tax increase • Comprehensive legislation, including adequate penalties for violations of the law • Complete ban on direct and indirect advertising • 100% smoke-free environment • Large, meaningful package messages (health warnings), memorable images • Widespread and sustained media campaign addressing the whole population and different audiences • Tackling of smuggling • Tobacco tax used for health promotion funds, particularly targeting smoking behaviour	• Controls on sales (age limits) • Controls on production • Measures focussed exclusively on youth • Voluntary agreements

For example, Austria's efforts to control tobacco consumption concentrate on (mostly ineffective, or even counter-productive) youth campaigns, the formal (yet not enforced) setting of age limits for the consumption and purchase of tobacco products (while permitting vending machines), and a very weak tobacco law with few provisions for sanctions or, even where they exist (as in the case of regulations of tobacco advertising), no enforcement. Although a certain percentage of tobacco tax is used to finance the national Fund for a Healthy Austria (activities in health promotion), and in 2002 the Federation of Austrian Social Insurance Institutions received a certain amount of the tax income, this money is not earmarked and the anti-smoking activities of both recipients are thus negligible or null. The delayed implementation of enlarged health warnings in September 2003 was more or less "enforced" by the European Union. The circumstances in which cigarettes are sold suggest that they are harmless, and information on health hazards is very limited.

The following measures have been recognised to affect tobacco consumption.[132] Again, in order to be effective, the importance of comprehensiveness, i.e. the implementation of several measures at the same time, has to be emphasised *(Section 4.3)*.

- Legal and regulatory measures
- Taxation and fiscal measures
- Environmental tobacco smoke (passive smoking): Smoking bans and restrictions
- Tobacco advertising, promotion and sponsorship
- Anti-smoking campaigns and other educational measures (information, training and public awareness)
- Therapeutic measures, smoking cessation

- Product control and consumer information
- Control of illicit trade (smuggling)
- Youth access

Due to the limited space in this thesis, the various measures, together with the response of the industry, are explored in more detail in Appendix F.

4.3 Reducing smoking: What works? Influential factors on policies

4.3.1 Introduction

Several countries have established successful measures to reduce smoking and may serve as "models of good practice" for other, less successful or less committed states, or for policymakers who still doubt the effectiveness of incisive tobacco control programmes. Apart from demonstrating the effectiveness of tobacco control interventions, the experiences of those countries that have committed themselves to reduce smoking prevalence, smoking-related death and disease also make it possible to reach conclusions about what are the most effective elements of tobacco policies.

Compared to the achievements in tobacco control in the United States (particularly in California and Massachusetts), Canada, Australia and New Zealand, but also other countries such as Thailand or South Africa, Europe as a whole can seem far behind. However, the Scandinavian countries, Sweden, Finland, and Norway, although not Denmark, can boast a long tradition of tobacco control policies. They have implemented very successful interventions for reducing smoking and are certainly the leaders in progressive anti-smoking policies within Europe. From the viewpoint of the situation in Austria, though, where anti-smoking policies remain underdeveloped, other European countries with comparatively limited programmes, such as Poland, France, Italy, the UK, or Ireland could also serve as examples. A particularly important issue at present in many European countries is that of smoke-free environments in restaurants, pubs and bars.

In Austria, anti-smoking policies from overseas (particularly in the United States, for Austrians the best known "negative" example of smoking restrictions), no matter how successful, are viewed as being rather eccentric, puritanical, militant, dictatorial, exaggerated and, all in all, "too extreme" – and by no means to be followed. Potentially, examples of successful interventions from other European countries might be viewed as more acceptable models. Therefore, this overview of successful interventions in controlling tobacco consumption puts more weight

upon the achievements by European countries, the underlying assumption being that these countries elicit fewer adverse responses in Austria and also that they seem to be more promising as arguments for a change in Austrian policies. Perhaps a glance over its own border could reassure those who fear hordes of desperate smokers in the streets and grieving restaurant owners in their empty premises, with the economy of the country in tatters.

However, given that the space available in this thesis is limited, a detailed overview of experiences from other countries has been placed in Appendix G. While in the following section only tobacco control programmes in European countries are discussed, the results from broader international experience will be considered when discussing the issue of environmental tobacco smoke and measures to restrict or ban smoking in workplaces. This seems legitimate as this discussion is based largely on evidence from outside Europe. Similarly, a summary of experiences in tobacco control from both European and further afield countries in the form of "lessons learned" will be presented in Section 4.3.4 and Appendix G. In due course these will form the basis for the development of recommendations for effective Austrian tobacco control measures in Chapter 10.

4.3.2 National strategies in selected European countries

This section will deal with those European countries that are at the cutting edge of tobacco control, featuring the most successful characteristic of each country. In particular the Scandinavian countries Sweden, Norway and Finland are outstanding within Europe in their sustained tobacco control policies, having begun their efforts to reduce tobacco consumption decades ago. In these countries, non-smoking has become a socially accepted cultural norm, and a smoke-free environment is part of the notion of a healthy environment. To some degree, smoking in northern European countries is now seen as a sign of social exclusion and deprivation.[135-139] A detailed description of the history of tobacco policies and the measures taken in these Nordic countries can be found in Appendix G.

The important achievements of other countries should not however be ignored. France, for example, is known for its early introduction of a total advertising ban (direct and indirect advertising, and sponsorship) in 1993[140] and a commitment to tobacco control by a series of health ministers since 1988 (starting with François Mitterand's administration but with the exception of Jacques Chirac), spearheaded by a strong media-based lobbying of a handful of committed medical practitioners.[141 142]

Austria's neighbour Italy, too, has had advertising bans since 1962, with provisions for fines since 1983 and the inclusion of indirect advertising and sponsorship since 1991.[140] In 2000, the Italian health minister introduced a proposal to ban smoking in public and private indoor areas open to the public, including bars, restaurants, prisons, and police stations, and to enable law suits against tobacco producers. People caught smoking in public places are fined €250, a sum that can be doubled if children or pregnant women are present. If restaurants and other public places wish to permit smoking they must set aside a smoking room and install a ventilation system – or risk a fine of €2,000 and temporary closure, a real revolution[143-145] *(Appendix G)*. A second law which came into force on New Year's Day 2004 limits the availability of cigarettes in vending machines.[146] Since 1 March 2004, smoking has also been banned on Italy's Eurostar trains.[147] While similar to Austria with its high smoking prevalence, a predominantly pro-smoking climate, and the notion of a "very tolerant society", Italy's achievements indicate that even in such conditions legal measures are effective, but also reflect the commitment of its health ministers Umberto Veronesi and Girolamo Sirchia.

Ireland has introduced a ban on smoking in all workplaces, including restaurants, pubs and bars in March 2004, thus being the first country within the European Union with a complete ban on smoking in the workplace *(Section 4.3.3)*. The ban also provides severe fines of around £2,000 (€3,000) for those caught smoking illegally. Ireland seems to play a particularly important role in initiating discussions on smoking bans even in reluctant countries such as Austria. In addition, as with Italy, the public approval if these measures in a country considered to be as individualistic and non-law-abiding as Ireland, with a traditional "pub smoking culture" nobody could imagine could be changed, shows that anti-smoking measures are not necessarily dictatorially enforced upon people, as argued in other countries. Examples like these will at least make counter arguments less believable. Italy and Ireland also demonstrate the importance and the potential of engaged and courageous health ministers.

In the United Kingdom, despite growing public support for a complete ban on smoking in public places, at present, there are no official restrictions for smoke-free environments in restaurants, pubs and bars; these are purely a matter of voluntary agreement. The government has, however, committed considerable resources to support smokers wishing to quit. While some commentators wanted to see the experience of the Irish smoking ban, a similar ban in England under the present health minister is not very likely.

Poland, on the other hand, is outstanding within the formerly eastern European countries. Despite enormous pressure from the tobacco multinationals, the Polish government has enacted

comprehensive tobacco control legislation first in 1995 (being far ahead its time compared to most western European laws on tobacco control) and amended by a law in 1999 *(Appendix G)*.[148 149]

Given the extent of the current debate about the scope for legislating for smoke-free environments in restaurants, pubs and bars, a debate that presumably will also reach Austria at some stage, the following section is dedicated to this issue.

4.3.3 Smoke-free environments in restaurants, pubs and bars

Restaurants, pubs and bars are among the most frequented public places where both smokers and non-smokers are involuntarily exposed to environmental tobacco smoke (ETS). Since the 1970s there has been growing evidence that second-hand smoke endangers non-smokers and, at least in the United States and north European countries, a reduction in social acceptability of smoking has accelerated its decline. This decline in social acceptability has been recognised by the tobacco industry to be one of the most serious problems it faces. Furthermore, smoke-free environments have led to a significant decrease in cigarette consumption and, consequently, to a loss of profits for the tobacco industry. In 1993, an analyst of Philip Morris observed:

> "Financial impact of smoking bans will be tremendous. Three to five fewer cigarettes per day will reduce annual manufacturer profits a billion dollar plus per year".[150]

The industry also recognised that declining social acceptability also increases voluntary quitting and weakens the industry's ability to develop allies.

In the face of these developments, by the late 1980s and early 1990s, the industry realised that it urgently needed to address these issues in a proactive manner, rather than simply reacting to some countries' tobacco control initiatives before they would spread out to other countries. To do this, several approaches were taken, one of these being attacks on science. A study by Drope *et al.* reveals the industry's deliberate strategy to use scientific consultants to discredit the science on ETS. They summarise their findings:

> "The industry built up networks of scientists sympathetic to its position that ETS is an insignificant health risk. Industry lawyers had a large role in determining what science would be pursued. The industry funded independent organisations to produce research that appeared separate from the industry and would boost its credibility. Industry organised symposiums were used to publish non-peer reviewed research. Unfavourable research conducted or proposed by industry scientists was prevented from becoming public."[151]

As will be shown in Chapter 9, Austrian scientists were also part of this game.

Other approaches were directed at influencing the public's perceptions, invoking arguments about "courtesy", "choice", "freedom", and (with a view to those who complained about smoking) "tolerance". It also used arguments that business would decline, accompanied by the promotion of ventilation as the best solution.[b]

> "The industry adopted two main approaches to address the problem of declining social acceptability of smoking: attacking the science demonstrating that second hand smoke was dangerous (as it had done with active smoking) and working to change the public's perception of smoking in public. The industry's original defence against restrictions on smoking (creation of non-smoking sections) in the 1970s was to invoke arguments about 'courtesy', 'choice', and 'freedom' as well as to claim that any limitations on smoking would hurt business ... (without mentioning the fact that tobacco industry sales and profits would suffer). In the 1980s they also began to promote ventilation as a solution." [150]

While these arguments clearly reflect the situation in California and northern Europe at that time, they also correspond to the present situation in Austria where the industry's early arguments about "courtesy", "personal freedom" and "own choice" are still courted, and where there is still a conviction that there is a simple solution: good ventilation systems *(Chapters 8 and 9)*.

However, as a result of these pressures from other countries, the tobacco industry started to focus increasingly on the debate about clean indoor air and smoke-free environments in the hospitality industry (restaurants and bars). Knowing that its public credibility is low, the tobacco industry has a well established practice of speaking through front groups.[150] In this case, the core message which was used to recruit allies in the hospitality industry and which is still dominant in Austria's perception of "tolerance", has been "accommodation" of smoking and non-smoking patrons *(Chapter 8; 8.4 and Appendix Q)*. Of course, there was no mention of the interests of employees. As has since been discovered, a key element in this strategy has been "to commission and release studies claiming that smoking restrictions have major negative economic effects on the hospitality industry, a claim even a PM *[Philip Morris]* lobbyist reported was untrue".[150]

Meanwhile, surveys particularly in California and northern European countries, but also in some other countries, indicate strong and increasing public support for smoke-free restaurants, pubs and bars. Apart from the forerunners in North America, Canada, North Europe, Australia and New Zealand *(Appendix G)*, now several more countries, including France, Italy, Ireland,

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[b] At least in some countries, this argument about ventilation "eventually lost credibility because a consensus developed that workers should not be forced to breathe the toxic chemicals in second hand smoke, and business saw no need to install expensive ventilation systems (that would not solve the problem anyway). In addition, many employers (particularly large employers) independently concluded that smoke-free workplaces were good for business".[150]

The Netherlands, and many cities in the USA (New York, for instance, banned smoking in public places in April 2003), have been enacting legislation to ban smoking in bars and restaurants.

However, despite the positive results achieved by smoking bans in restaurants and the strong community support found in many studies, the tobacco industry, hospitality associations, restaurant lobbying groups, and many restaurant owners have been consistently opposing proposals to restrict smoking in restaurants, arguing that smoke-free policies would result in a loss of business by successfully echoing the unfounded arguments developed and reinforced by the industry.

To date the industry has remained constant in its encouragement to maintain the "controversy" on ETS (although there is no real controversy). As pointed out by Bartosch & Pope[152] and other authors, tobacco and restaurant industry funded studies claim that restaurant jobs would be lost and/or restaurant sales would decline under such restrictive policies – arguments still used by Austrian media and health politicians. Yet these claims are unwarranted. Dearlove and colleagues describe how the tobacco industry used the "accommodation" message to mount an aggressive and effective worldwide campaign to recruit hospitality associations, such as restaurant associations, to serve as the tobacco industry's surrogate in fighting against smoke-free environments.[150]

In reality, there is good evidence from independent studies in the USA, Canada and Australia that turnover is not affected, or has even increased after the introduction of smoke-free restaurant and bar laws.[153 154]

The strongest argument in favour of smoking bans in all public places is the scale of the health hazards from environmental tobacco smoke that both non-smoking patrons and employees are exposed to. An investigation in New Zealand tried to quantify the actual extent of exposure of hospitality workers to ETS during the course of a work shift, relating the results to the customer smoking policy of the workplace. The results of this investigation showed that hospitality workers in premises allowing smoking by customers had significantly greater increases in salivary cotinine concentrations than workers in smoke-free premises and those in premises with no restrictions on customer smoking were more highly exposed to ETS than workers in premises permitting smoking only in designated areas. Overall, there was a clear association between within-shift cotanine concentration change and smoking policy. In addition, workers in premises permitting customer smoking reported a higher prevalence of respiratory symptoms and irritation than workers in smoke-free workplaces. Concentrations of salivary cotanine found in

exposed workers in this study were at levels consistent with substantial involuntary risks of cancer and heart disease[155] *(Chapter 7; Appendix L).*

A recent study from the United Kingdom estimates that one hospitality worker a week dies from passive smoking.[156] Not even these alarming results are enough to stimulate a serious prospect of public smoking bans, neither in the United Kingdom itself nor in Austria, where this study was also reported in the media.

According to an Australian study by Trotter *et al.* to assess the perceived effects of smoking bans in bars, nightclubs, and gaming venues on smoking behaviour, 70% reported that they would smoke more (socially cued smokers) and 25% (especially young people aged under 30 years) indicated that they would be likely to quit if smoking were banned in social venues.[157] Thus, these findings confirm what is already known from other countries where smoking bans have been established for a couple of years: that the introduction of smoke-free policies could reduce cigarette consumption and increase quitting among smokers.

In England, a total ban on smoking in public places, including pubs, bars, restaurants, and other workplaces, was proposed by the chief medical officer, Sir Liam Donaldson, who pointed to the increased risks of passive smoking, especially for children and babies, but also for adults. He even noted that action on second-hand smoke was what the tobacco industry has long feared most.[158] Reacting to this proposal, Simon Clark, director of pro-smoking and industry-funded group *Forest*, used the standard formulation of the tobacco industry and their allies in the restaurant business:

> "We are against a total smoking ban in public places, we believe there is no justification for it. Pubs, restaurants and clubs are private business and they should be free to choose their own policy... We would actually like to see more non-smoking areas. We are prepared to compromise but the anti-smoking industry is not willing to do the same".[158]

It is not quite clear what Mr. Clark imagines to be the "anti-smoking industry" (obviously some sort of organised, relentless and very powerful enemy) but what is very clear is that the health hazard of passive smoking is not at all an issue for him. Sir Liam Donaldson's proposal was not, however, supported by his health minister, who favours local action where agreement can be achieved.

Forest's arguments are similar to the view expressed by the Austrian State Secretary of Health, Reinhart Waneck, who is strictly opposed to smoking bans in restaurants and bars, using strong words when arguing that smokers should not be "criminalised" and ignoring successfully the fact of health hazards in favour of further gains from tobacco taxes.[159]

Luckily, there are several states that have been more successful in the past and can report positive effects of smoking restrictions based on lengthy experience, although obviously attribution of health effects to smoking bans is complicated by the co-existence of other measures. Some states in North America (in the forefront are California and Massachusetts), Canada and Australia long ago banned smoking in restaurants and bars *(Appendix G)*, and there is evidence that not only smoking rates but also smoking-related mortality decreased significantly.[160] For example, Canada, California and Massachusetts report a significant decline in smoking rates.[160-166] California has also experienced a significant decrease in mortality from myocardial infarction and lung cancer.[161] In Canada, too, the impact of the decline in smoking prevalence is beginning to show in decreased lung cancer rates among Canadian males aged 20 years and over.[167]

Other countries, states or cities have recently issued a total smoking ban in public places (including restaurants and bars), as, for instance, Thailand, New York, Ireland, and Norway. Other countries are following.

In the Nordic countries (especially Norway, Sweden, Finland, and Iceland), in general, ETS has been tackled fairly heavily over the last years. Although Denmark still has much to do, all countries share the challenge of transforming restrictions into bans, but Norway is the only country that has a complete smoking ban in restaurants and bars, entering into force on 1 June 2004. Sweden will follow suit on 1 June 2005. The Norwegian bill ensures equal protection for all employees in their working environment, but also protection of customers and removal of an important setting in which teenagers might start smoking. A glance behind the curtains reveals some of the key criteria that influenced the passing of this bill:

> "A success criterion for the progressive legislation is the fact that the influential labour unions gave their full support and campaigned actively for the outcome. Another was the decision of the Supreme Court that ruled in favour of a plaintiff who sued for damages due to illness caused by exposure to passive smoking in a bar. The new act is an example that legislation enacted at an opportune time can be a powerful public health tool".[137]

In Norway, separate areas for smokers and non-smokers in restaurants and cafés have been highly appreciated for many years. According to a survey conducted in 2001, about two thirds of the population prefer the non-smoker's area. Only 10% found the 50/50 areas too strict – 90% found it balanced or too weak. The new provisions for totally smoke-free restaurants have more moderate, but still majority support. A poll conducted in May 2003 showed 53% in support, while 44% were against and 3% were 'don't knows'.[137] However, experience of previous

restrictions and experience in other countries show that public support increases after the introduction of smoking restrictions.

In Finland, despite considerable effort and the general success of tobacco control policies, it has been difficult to enforce smoke-free legislation for bars and restaurants. Restaurant and bar owners reported finding it hard to implement the legislation, and a softer approach did not have the intended effect. Restaurants and bars have to set aside non-smoking areas, but these can hardly be called smoke-free as they adjoin smoking areas. The three-year transition period ended on 1 July 2003. Now restaurants and bars of $50m^2$ or over must reserve half of their seats for non-smokers. Smoking areas must be ventilated so that tobacco smoke does not spread to the smoke-free area.[137]

In summary, therefore, smoke-free environments not only offer protection from passive smoking; they also constitute a key element in reducing smoking prevalence among young people.[137]

Counter arguments

One of the most frequently used counter arguments against total smoking bans is the magic word "ventilation". Ventilation systems are not effective because ETS consists of particulate and gaseous materials that are difficult to remove. Also factors such as design of the room, number of patrons, building materials and temperature make it impossible to design a ventilation system that will remove all the constituents of ETS.[168-170] To achieve a "clean" indoor air quality which is within limits set for outside air pollution, the ventilation would need the strength of a tornado, with about 40,000 air-changes per minute.[169-172] In addition, ventilation systems that make any difference to air quality are very expensive and not easily affordable. The introduction of smoke-free environments is certainly the cheaper and more effective intervention to reduce both harm and annoyance.

Another argument is the allowance that "everybody" (i.e., in particular, smokers) has the "right" to smoke, being a matter of freedom of choice and implying that neither the state nor "intolerant" non-smokers have the right to interfere.

Confronted with evidence of the health hazards of ETS for non-smokers, it is often argued that the case is not scientifically proven. Although studies on health hazards resulting from second-hand smoke are difficult (due to the difficulty in measuring previous exposure to ETS and conducting appropriate follow-up studies), there have been numerous studies (more than 42 case-control studies and 6 longitudinal studies) from many countries over the last two decades that

demonstrate a relationship between exposure to ETS and increased risk of smoking-related diseases in non-smokers – particularly increased risk of lung cancer and other respiratory diseases in hospitality workers and life partners of heavy smokers, and increased risk in respiratory diseases in children of smoking parents. ETS contains more than 50 human or animal carcinogens and because much of it arises from smouldering cigarettes, burning at lower temperatures than with active smoking, it is more toxic than smoke inhaled actively.

When all its arguments proved unsuccessful, the industry and its allies attempted a last try: surely one can solve this problem with less dramatic measures, usually involving another magic word: "tolerance" (by non-smokers, obviously, whatever that means). But many restaurants and bars may find it difficult to separate their premises so that non-smokers will not feel harassed by the smoking of others and, as already noted, the cost of a "good" ventilation system is high (and it does not make much difference either). For most restaurants and bars it would therefore be easier to provide total smoke-free environments than divided sections.

4.3.4 Lessons learned

The experiences in tobacco control in countries and states that have been examined most closely (United States, Canada, Australia, New Zealand, Norway, Finland, Sweden, Brazil, Poland, South Africa, and Thailand), all point to one main finding: tobacco control measures can work. Although the situation in each continent, in each country, state, or city is different and to a certain degree unique, there are commonalities that are applicable to other countries in different settings.[173] Many lessons have been learned about what works, from both the successes and the setbacks and may now serve as guidelines for other countries.

A summary of measures that have proven to be effective in tobacco control in various countries as well as measures that meet the interests of the tobacco industry (many of them to be found in Austria's tobacco policies) is given in Appendix G.

The following chapter presents the international framework European tobacco control policy is embedded in. This consists in particular of the binding laws and regulations of the European Commission, but also of various policy initiatives by the World Health Organization and the European Union.

5 THE INTERNATIONAL FRAMEWORK: EUROPEAN SMOKING AND TOBACCO POLICY

Since 1989, when the European Community passed its first directives on labelling, advertisement and smoking restrictions in the workplace, and particularly since 1999, when negotiations for the Framework Convention on Tobacco Control (FCTC) "have opened the door to global agreements that aim to reduce tobacco consumption and the related death toll worldwide"[132], the tobacco control climate has changed considerably. The decision by the European Union to legislate on tobacco and the FCTC process launched by the WHO were responses to the increasingly global nature of the tobacco industry with its inventive and aggressive strategies to undermine national legislation (e.g. smuggling, cross-border advertising in television and printed media, etc.).[174] [175] These new developments made it increasingly necessary to enact supranational legislation.[27] [142]

Therefore, within the wider framework of European tobacco policy, particularly with regard to the laws and regulations on production, marketing, taxation and advertising of cigarettes established by the European Union, tobacco control is no longer a national issue and policies pursued by individual governments in Europe cannot be seen in isolation from those being pursued by the European Union.[27] For Austria, like most other European countries, the need for effective supranational tobacco control policies becomes evident from the persistence of weak national policy measures. Where changes have taken place they have often been in response to European law and would otherwise not have been initiated.

This chapter, therefore, identifies the main actors in European tobacco policy, describes the legislative situation at the European level and addresses the various actions and programmes initiated by these actors.

5.1 Actors on the European level

The two main actors in European tobacco policies are the World Health Organisation (WHO) and the European Union (EU), formerly the European Community (EC).[a] The World Bank, an important actor on the global level, also has some influence on European tobacco policies. For example, after reviewing the evidence regarding the effects of cigarette advertising, the World Bank concluded that advertising increases cigarette consumption so that legislation ending ad-

vertising would reduce consumption – provided that it was comprehensive, covering all media and uses of brand names and logos. A modelling exercise applying these data to the entire European Union (then 15 countries) led the World Bank to conclude that the comprehensive advertising ban outlined in the – later annulled – 1998 EC directive (98/43/EC) would have reduced overall cigarette consumption within the EU by 7%. From a public health perspective, such a reduction in cigarette consumption would have immediate short-term and long-term benefits.[176] In tobacco control, the World Bank itself sees its role as a partner with the World Health Organization, which is recognised as the lead organisation in responding to the epidemic (particularly with its Tobacco Free Initiative), while offering in particular its economic perspective.[3]

The United States Centers for Disease Control and Prevention (CDC) also have some indirect influence on European tobacco policy through their important publications (e.g. reports of the Surgeon General) but cannot be considered a major actor at the European level.

Last but not least, many non-governmental or EU-funded organisations and agencies, such as the now disbanded Bureau for Action on Smoking Prevention (BASP), the Association of European Cancer Leagues (ECL), the International Union against Cancer (*Union Internationale Contre le Cancer*, UICC), the British advocacy organisation Action on Smoking and Health (ASH), or the International Agency on Tobacco and Health (IATH), have all played an important role in influencing European tobacco policy.

5.1.1 The European Community (European Union)

According to Article 95a, the EC is mandated to pursue "a high degree of public-health protection". As of 2003, EC tobacco control legislation is still generally weak, although two recent directives, 2003/33/EC which bans cross-border advertising and sponsorship and 2001/37/EC which, inter alia, bans misleading product descriptions such as "light" or "mild", have led to considerable strengthening of efforts to reduce cigarette consumption in Europe, particularly in the context of enlargement, although as noted above, some acceding countries such as Poland have more stringent laws than existing member states.

Starting in 1989 with the first directives on tobacco control – i.e. the television advertisement (or broadcast) directive "Television without frontiers" 89/552/EEC; directive 89/622/EEC concerning labelling of tar and nicotine yields and health warnings; and directive 89/654/EEC con-

[a] After the Maastricht Treaty in 1992, the former European Community (EC) became the European Union (EU).

cerning the minimum safety and health requirements for the workplace – the European Union has enacted several directives and recommendations to control tobacco consumption, in particular with regard to product labelling, maximum yields for tar and nicotine in cigarettes, tax levels, advertising and sponsorship *(Section 5.2 and Table I-1 in Appendix I)*.

A major set-back that had far-reaching significance was the annulment by the European Court of Justice (ECJ) in October 2000 of directive 98/43/EC that had established a comprehensive ban on tobacco advertising *(see later)*. The ECJ's verdict illustrated the legal subordination of public health to internal market issues, or the so-called harmonisation of the single market. Although the treaties require that the European Union pursue a "high level of protection for public health", they place constraints on the scope to pass legislation for purely public health purposes. Most tobacco control legislation has therefore been enacted on the basis of internal market provisions – even though it concerns trade in a substance that kills more of its citizens than any other. The advertising directive was overturned on the grounds that it was enacted as an internal market issue but was deemed to obstruct rather than facilitate trade in tobacco products.[175]

Thus, overall, the role of the European Union in combating tobacco consumption has been somewhat disappointing. According to Collin & Gilmore, the weakness of the European position can be explained "by a combination of the deficiencies in European tobacco control legislation and a lack of political will".[175]

However, although the weaknesses, delays and omissions in European tobacco control legislation and the economic might of the tobacco industry cannot be ignored, the positive influence of the existing directives on the progress of national tobacco policies, at least in some countries, has to be recognised. Section 5.2 will explore in more detail the legislative framework for European tobacco control.

5.1.2 The World Health Organization

In the 1980s and 1990s, policymakers became increasingly aware that smoking is not only – as previously believed – an issue of personal responsibility and individual behaviour (arguments successfully propagated by the tobacco industry), but also a social issue that should be subject to health policy. The scale of the health consequences of smoking compelled the World Health Organization, the principal international agency responsible for health, to give concrete recommendations to its member states for containing tobacco consumption over many years.

Since 1987, three five-year European Action Plans on Tobacco have been launched (1987–1991; 1992–1996; 1997–2001).[177] Meanwhile, the WHO has taken the lead in responding to what is now termed the "tobacco epidemic" through its Tobacco Free Initiative (TFI). The most significant action arising from this initiative is the WHO Framework Convention on Tobacco Control (FCTC) *(Appendix H)*. Prior to the launch of negotiations in October 2000, the following statement was issued jointly by EU Health and Consumer Affairs Commissioner, David Byrne, and WHO Director General, Dr Gro Harlem Brundtland.

> "Tobacco use is the most significant avoidable source of disease and premature mortality. In the European Union alone, over 500,000 deaths per year are caused by tobacco consumption while globally 4 million die annually from tobacco. Smoking leads to significant death and disease from cancer, cardiovascular disease and respiratory disease in adults as well as severe health effects in children exposed to tobacco smoke. The death toll caused by tobacco consumption can and must be avoided."[29]

The FCTC is a unique framework-protocol approach[b] which will come into force only after 40 countries ratify. Ratification, acceptance, approval and accession are international acts by which states that have already signed the FCTC signify their consent to be bound by it. To date (4 August 2004) there are 168 signatures; Austria signed on 28 August 2003. Twenty-five countries have ratified the convention so far, with Norway being the first.[179] As soon as 40 countries expressed their consent by ratification, the Convention will become law for those countries and thereafter for other countries that become contracting parties to it.

The FCTC process arose from the recognition that individual states can no longer effectively control the global factors that drive the tobacco epidemic. This convention offers a unique opportunity to tackle this pandemic, although progress has been inhibited by some key states *(Appendix H)*.[174 175]

Despite known problems with implementation of the convention (scientific uncertainty, complex technical details, and – presumably most importantly – lack of political will)[178], the FCTC process has already had a major impact in advancing global and national tobacco control efforts. So far, the tobacco industry has been relatively mute (or is still offended at not being in-

[b] Frameworks describe an agreement on broadly stated goals. Subsequently, the parties will possibly conclude separate protocols with specific measures to implement these goals. Unlike a framework, a protocol is an international agreement, which can be adopted or accepted.[178]

cluded[c]) but is expected to engage in the fight at the national level, trying to ensure that implementing legislation is weak with many loopholes and continuing to promote self regulation as the answer to the tobacco pandemic.[181] Consequently, it is most important that more countries ratify and implement tobacco control legislation as soon as possible. In the words of Hammond and Assunta: "Without a swift and concerted action to bring the FCTC into force and ensure that countries implement it to the fullest, there is the danger that the treaty will end up as just another well intentioned resolution."[181]

However, the role of the WHO was not always as pronounced against smoking. A 1979 industry memorandum regarding the industry-organised International Public Smoking Symposium (ICOSI) discloses that the then WHO sub-director, Mr. Tibblen, would though "not be totally on our *[the industry's]* side" but his remarks would be "fairly moderate". He would thus help a "balanced" or even "controlled controversy" where his views were then going to be discredited.[182] [183] [d]

In 1993, the WHO was described by the industry as rather weak (due to its limited funding), though influential.[e]

An overview of effective interventions, actions and programmes by the WHO and the EU can be found in Appendix H.

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[c] In its position paper on the FCTC of 21 February 2003 Gallaher expresses its disappointment at being passed over (something it has not been used to, obviously): "Gallaher is disappointed that tobacco manufacturers have been largely excluded from the process of developing the Framework Convention, other than an opportunity to submit a four page written statement and to make a five minute presentation at the October 2000 Geneva Convention. Article 5.3 of the Framework states that the parties are asked 'to avoid undue interference by the tobacco industry'. No matter what views those responsible for the proposed Framework may have, Gallaher contends that balanced debate, that truly takes account of the interests of all parties, is more likely to result in principles and goals that are more appropriate and more proportionate in their aims".[133]

BAT spokesman Michael Prideaux expressed the industry's anger as follows: "The WHO has been taken over by a coalition of anti-tobacco activists whose stated purpose is to hound tobacco companies out of business... Tobacco is not an environmental issue which needs a supra-national convention. It is a consumer product and best regulated by the people that consumers vote for." This argument becomes more transparent when he says shortly afterwards: "National governments earn ten times as much money from the tobacco industry as we do. They have no desire to put us out of business." What he did not quite understand was why, "while BAT and the other tobacco companies could not take part in negotiations with the WHO, anti-tobacco groups such as Ash were involved in the talks".[180]

[d] This just shows the carefully prepared tactics of the industry: "If Tibblen makes his point ... The response to Tibblen will come from carefully briefed and placed floor discussing people."[120]

[e] "In light of its poor funding arrangements, the WHO cannot be looked upon as the powerhouse for smoking control around the world. The monies it does have available are basically 'seedcorn', to provide the framework and climate through the media for the growth of smoking control strategies in the Member States."[184]

5.2 EU legislation and non-binding provisions

Although much of this section has had to be placed in Appendix I because of space limitations, it is mainly drawn from the framework developed by Gilmore & McKee[27] and the publications by Gilmore & Zatonski[149] and Gilmore *et al.*[185], updated by the latest information from EU websites[28 29].

The various EU Directives regulate the contents, packaging and labelling of tobacco products; they impose an obligation to provide health warnings; and they ban direct tobacco advertising in print media, on television, on the radio, and on the Internet.[29]

As European law takes primacy over domestic law, member states must incorporate Directives enacted by the European Council and Parliament into national law within a defined period (usually two years). A failure to do so means that the directive automatically becomes legally enforceable in the state in question.[27]

Where the law dictates that the EU cannot (or does not want to) legislate, but the member states can, the EU has developed a complementary set of non-binding recommendations for member states. These are, for example, the Council Recommendation 2003/54/EC on the prevention of smoking and on initiatives to improve tobacco control – including tobacco sales to children and adolescents; tobacco advertising and promotion that has no cross-border effects; provision of information on advertising expenditure; environmental effects of tobacco smoke – or Council Resolutions on combating tobacco consumption, on reduction of smoking, and on banning smoking on the workplace and in places open to the public.[28 29 149]

The issue of smoking in the workplace and other public places has yet to be addressed effectively at a European level. A directive regulating smoking in the workplace (89/654/EEC) and a specific directive on measures for the safety and health at work of pregnant or breastfeeding workers (92/85/EEC) are being revised[186] *(Appendix I).*

Similarly, a weak, non-binding resolution of 1989 invites member states to adopt measures to end smoking in public places and on all forms of transport[176]. David Byrne, the outgoing EU Commissioner for Health and Consumer Protection, has recently asserted his determination to strengthen smoke-free policies in Europe.[187]

Although there are also some other regulations in effect (e.g. a directive regulating taxes (99/81/EC), the television broadcast or advertisement directive (89/552/EEC), etc.), the present

6 PATTERNS OF SMOKING IN AUSTRIA

6.1 Introduction

This chapter analyses current and historic smoking patterns in Austria. In particular, it looks at the social determinants of and attitudes towards smoking. Existing surveys containing information on smoking were identified and explored. However, the various studies available differ in the questions used, sample size and sampling methods, and methods of analysis. Thus, it was concluded that the most useful aggregate information was that from a recent survey on smoking behaviour in Austria, based on the results of the December 1997 Microcensus. This report, published in 2002, includes comparisons with comparable previous surveys and contains both a detailed description of the methods of data analysis and a comprehensive interpretation of the results. Where appropriate, these data were complemented with information from the latest Microcensus on health in 1999, although this included only one question on smoking status. In the case of Vienna it was possible to obtain access to the raw data from the Vienna Health and Social Survey, conducted in the winter months 1999/2000 and 2000/2001, and thus to undertake a more detailed analysis in which the relationships of various correlates with smoking could be explored using logistic regression.

6.2 Surveys on smoking

Most national surveys containing information on smoking in Austria have been performed by Statistics Austria. In particular, these are the *1997 Microcensus* with its special section on smoking habits (December 1997, hereafter abbreviated as smoking survey)[11], the *1986 Microcensus* with its special section on smoking habits and health (September 1986), and the *1991 and 1999 Microcensus* focussing on health, which included one question on smoking status (December 1991 and September 1999).[44] All surveys in the microcensus programme are conducted in form of oral interviews in private households and comprise sample sizes of about 60,000 persons aged 15/16 years and over *(Appendix J)*.[a]

[a] The quarterly conducted microcensus surveys are established in law since 1967 (BGBl. Nr. 334/1967). The survey consists of a basic part with a set of consistent questions and a special part with varying topics from the areas of social or health statistics. However, while everyone is obliged to give information as to the basic part, the interviewees are free to answer the questions of the additional special part of the microcensus (e.g. microcensus on health, microcensus on smoking habits, microcensus on smoking and health).

legislative situation with regard to tobacco control is characterised by the three latest directives and recommendations of the European Commission: the Tobacco Products Directive (2001/37/EC)[188], the Advertising and Sponsorship Directive (2003/33/EC)[189], and the Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control (2003/54/EC)[190]. These and an overview of all major EU tobacco control regulations since 1989 are presented in two tables in Appendix I.

Appendix I also gives a more detailed description of regulations on advertising and sponsorship, labelling and cigarette composition, and smoking in public places and workplaces.

Separately from these surveys, a small self-completed questionnaire survey was conducted by the Austrian Nicotine Institute and the associated Institute of Social Medicine of the University of Vienna on a sample of nearly 5,000 individuals at the end of the 1990s.[53] This survey was primarily done to assess the Austrian market for measures on smoking cessation.[b] This and the fact that this survey is less representative than the microcensus are the reason why this survey will only be considered regarding its findings about the smoker's willingness to reduce or stop smoking when discussing the attitudes towards smoking in Austria *(Section 6.3.5; Appendix K)*.

For children and young people, data from the WHO Study on Health Behaviour in School-Aged Children (HBSC study[12 13 192]) are used.

On the regional level, there have, however, been a variety of other surveys conducted in individual cities or federal provinces. Vienna (being both a city and a federal province) in particular has been the setting for several surveys which address, among other subjects, smoking behaviour. The City of Vienna, for example, commissioned the *Vienna Health and Social Survey 2000/2001*. Some results, so far only partly analysed, have been published in a variety of reports.[46 49] It also commissioned and published the regional analysis of the *1999 Microcensus on Health in Vienna*.[48] Examples of other surveys initiated and financed by local governmental offices are the 1995 mega-survey on *Life in Vienna,* undertaken by the Institute for Empirical Social Research (IFES)[52], which was repeated in 2003, and the series of surveys from the *Vienna Study on Addictive Drugs*, last conducted also by IFES in 2001.[51] A more detailed description of the various surveys can be found in Appendix J.

The federal provinces that were traditionally more active in the area of health surveys and health promotion are Vienna, Upper Austria (in particular the capital Linz), Vorarlberg (Bregenz and Dornbirn) and Styria (Graz). Apart from Vienna, however, only Styria has data on smoking behaviour at a regional level, drawn from cross-sectional health surveys conducted between 1989 and 1993, which included 14 questions on smoking.[50] However they are not fully representative as they were conducted in 79 rural communities and thus exclude cities. All other regions must use data from the microcensus, disaggregated by provinces.

[b] For example, by referring to the result of a 'representative' Austrian survey by the two institutes *(Chapter 9)*, according to which the majority of smokers would like to reduce smoking rather than quit, Kunze and Groman state that they would rather prefer campaigns for those willing to reduce smoking than campaigns aiming to get people to stop smoking *(sic)*.[191] (In fact, there are no campaigns at all that are targeted at adults, whether suggesting to reduce or to stop smoking.) Being the national representatives for Austria in all international committees, Kunze and Groman also provided these data on smoking prevalence to international bodies.

There are, however, several relevant activities currently underway in some of these provinces. Upper Austria, for example, has been targeting smoking as a major health issue, with the declared target of reducing the number of young smokers to less than 95% of the present rate by 2004. A survey is currently (2003) being planned that will cover 8,000 children in Linz. In Vorarlberg, the Institute for Addiction Research (Dornbirn) is currently (2003) planning a survey addressing alcohol consumption and smoking among teenagers.

6.3 Data on smoking in Austria

In essence, therefore, there are two main sources of data on smoking in Austria: the microcensuses that have specific sections on smoking; and those that only ask a single question. However the figures differ and other sources, derived from other surveys or international studies (e.g. Eurobarometer, HBSC study) produce figures that are not identical with either of these. It should be noted, though, that figures for smoking prevalence derived from Eurobarometer in other countries are also suspect, producing rates that are often inconsistent with specific health surveys.[193]

This chapter is therefore based mainly on the results of the survey on smoking habits, last conducted in 1997 within the framework of the microcensus programme of *Statistics Austria*[11], supplemented where possible by the results of the latest 1999 microcensus on health[44 194]. For the discussion on smoking in Vienna, however, the 1999 microcensus had to be used. Both surveys are based on interviews of 60,000 individuals aged 16 years and over (1997 survey) or 15 years and over (1999 survey). However, in addition to the minor differences in the age coverage and the two years time span, the two surveys are not comparable. The 1997 survey was an explicit survey of smoking behaviour, using several questions and filters, whereas the 1999 survey was a general health survey, including only one question on cigarette smoking.[c] There is also reason to believe that the substantial differences in smoking rates between the two surveys might arise from important flaws in the statistical process of imputation[d] used in the 1999 survey.[195]

Consequently, the different results of the two types of surveys are not strictly comparable and allow no conclusions to be reached about developments over time. Comparisons are possible

[c] The questions contained in the two surveys are listed in Appendix J.

[d] To counteract the problems of non-response (total non-response or item non-response), *Statistics Austria* developed a method of imputing missing values. Using socio-demographic characteristics, the most resembling respondent is being determined and the missing values complemented accordingly.[195]

only within each type of survey, for instance comparisons between the 1991 and 1999 micro-census on health (although even these surveys are not really comparable because of different questions), or comparisons between the 1997 smoking survey and similar surveys in 1986, 1979 and 1972. Taking all these factors into account, an in-depth analysis on the most recent data is only possible on the basis of the 1997 smoking survey with its comprehensive and altogether more reliable data, which was therefore chosen as main source for this chapter.

Notwithstanding these limitations, it is possible to infer some broad trends over time, with different developments among men and women, and those of different ages and social groups, etc., while not attributing unjustifiable precision to the numbers of smokers, which can only be approximations.

Again, due to the limited space in this thesis, a more detailed analysis of smoking rates in Austria may be found in Appendix K.

6.3.1 Smoking rates in Austria

According to the 1997 Microcensus on Smoking Behaviour, conducted by *Statistics Austria*, almost 30% of the Austrian population aged 16 years and over smoke, and nearly one quarter (24%) smoke on a daily basis. Roughly one quarter of the daily smokers are considered heavy smokers, smoking 20 or more cigarettes per day. Nevertheless, the number of ex-smokers is increasing and in 1997 represented 17% of the Austrian population, corresponding to a quit rate of 37%. More than half of all interviewees (53%) had never smoked (never-smokers) and 17% had given up smoking (ex-smokers), totalling 70% of non-smokers. The rate of non-smoking among females is even higher (77%).

As in other countries, Austrian men smoke more frequently than women; they are also more likely to be ex-smokers. In 1997, 36% of men and 23% of women smoked, the vast majority of them daily (men 30%, women 19%).

Of Austria's population, 17% of men and 4% of women are heavy smokers (more than 20 cigarettes per day), thus representing 29% of all men who smoke daily and 14% of all women who smoke daily. The majority of daily smokers (51% of men and 48% of women) smoke 11 to 20 cigarettes per day.

In 1997, the highest smoking rate was found among young male adults aged 20 to 24 years (48%). However, while for men, smoking becomes less common with age, the proportion of

female smokers rises until the age of 35 to 39 years (37%) before declining again. Very low smoking rates are found in older age groups, in both men and women. Of 60 to 64 year old men, only 19% smoke, and in the age group of 75 years and over the figure is even lower (11%). Of 60 to 64 year old women, 9% are smokers, but the rate hardly decreases in women aged 75 year and over.

As in other countries, smoking among adolescents is increasing in Austria, and a clear gender difference in trends in teenage smoking can be observed over the last decade. While tobacco consumption among boys has declined, daily smoking among 15 year-old girls has become more frequent. In an international comparison, Austrian teenagers (especially girls) rank very high with regard to both alcohol consumption and cigarette smoking. One in four girls and one in five boys aged 15 years smoke daily, placing Austrian teenagers in fifth position among all countries surveyed.

The average age of taking up smoking has changed dramatically over recent decades and a clear shift towards younger age groups can be observed, especially in women. In 1997, more than half of daily smokers had started smoking habitually before the age of 17. Above this young age smoking is rarely commenced.

Particularly for women, but also for men, smoking is more frequent in urban than in rural areas. Vienna, for example, has the highest proportion of heavy smokers. More than half of the Viennese population aged 15 years and over smoke at least occasionally; 44% smoke daily. While the figures must be interpreted with caution because of methodological limitations, among the female population an apparently dramatic increase of daily smokers by 45% between 1991 and 1999 is observed, while the increase for men was only 12.5%. In 1999, 48% of Viennese men and 40% of Viennese women were daily smokers. However, 'only' 10% of men and 5% of women are heavy smokers, indicating a marked decrease in heavy smokers since 1991 – especially in men, who show a reduction of 50%. There has also been an increase in daily smoking among teenagers and young adults, especially among females.

6.3.2 Socio-economic determinants

Socio-economic factors, such as education, employment status, income and job position, are known to affect lifestyle and behavioural patterns, such as alcohol consumption or smoking.[196] Education, for example, is not only an important determinant of achievement of social and professional status; it is also related to health awareness and the ability to adopt health conscious

behaviour. It therefore influences receptiveness to both tobacco advertising and health promotion activities. The usual indicator for assessing educational level is the highest school graduation level or academic degree achieved by an individual.

In developed countries it is now a common finding that members of higher social strata smoke less than those in lower social strata. In Austria, however, this assumption cannot wholly be confirmed as yet.[11] Although men with the highest educational level (university degree) indeed have the lowest smoking rates, due both to the high proportion of ex-smokers and never-smokers, and men with the lowest educational levels had the highest rates of smokers and an above-average proportion of ex-smokers, hardly any differences could be identified for the groups in between. Women showed a strong polarisation in the lower educational groups but no obvious differences could be found in university graduates.

I undertook a more detailed analysis (using logistic regression) of the Vienna Health and Social Survey looking at socio-economic determinants of smoking. Data were adjusted for the factors that appear to have the strongest influence: age, employment and education *(Chapter 2; 2.2.3)*. This analysis shows clearly that unemployment in particular plays a significant role in smoking behaviour, especially for men. Other influential variables are age (for both sexes) and education (for men). Results of this analysis are described in more detail in Appendix K.

6.3.3 Trends over time

A comparison of smoking rates in Austria over the last three decades reveals that the increase in smokers has not been steady; in addition, tobacco consumption patterns have developed differently for men and women. From the beginning of the 1970s until the mid-1980s, the proportion of smokers and ex-smokers rose steadily. Since the 1980s, however, the proportion of smokers has decreased slightly while the proportion of ex-smokers has increased markedly. Nevertheless, while smoking seems to be becoming less common among men, smoking rates among women have increased noticeably. Since 1986, however, the proportion of daily smokers has declined for both men and women, accompanied by a preference for lighter cigarettes.

Altogether, between 1972 and 1997, the male smoking rate decreased by 21% (from 45% to 36%), while the female smoking rate increased by 78% (from 13% to 23%). As with men, the proportion of women who had stopped smoking (ex-smokers) increased markedly over that period of time. Accordingly, since 1972, the proportion of never-smokers has been growing slightly but continuously among the male population, while falling significantly among the

female population. Nevertheless, the proportion of non-smokers is much higher among the female than the male population.

6.3.4 Smoking in Austria compared to other EU countries

In comparison with the rest of Europe, smoking rates among both men and women in Austria lay well above the European average in 1999. According to these figures, Austrian men rank fourth, Austrian women fifth among the 15 EU member states.

6.3.5 Attitudes towards smoking / smoking cessation

In 1997, 1.1 million ex-smokers were living in Austria. The general quit rate for Austrian men is reported to be 38%, for Austrian women 35%. There are, however, certain groups of the population who are more successful (i.e. display a higher quit rate) than others. For example, the tendency to stop smoking increases with age. For young women, pregnancy and childbirth represent the main reasons for giving up smoking. Education also plays a significant role. However, reflecting the success of the tobacco industry in promoting their vision of a "safer" cigarette, many people see switching to lighter cigarettes as an alternative to giving up smoking completely. Almost one in four of daily smokers have changed their preferred brand over the last five years, women more frequently than men.

6.3.6 Hazards from passive smoking

In 1997, one third of all employees reported that they were exposed to second-hand smoke at their work place, and more than one third of those affected felt harassed by the smoking of their colleagues, women more often than men and non-smokers more often than ex-smokers.

As noted, a detailed analysis of smoking patterns in Austria can be found in Appendix K.

The next chapter will examine what is known about the impact of tobacco on health in Austria.

7 TOBACCO-RELATED DISEASE AND MORTALITY IN AUSTRIA

7.1 Introduction

While aggregate measures, such as life expectancy, can act as indicators of the general level of health of a country, the health impact of certain risk factors, such as tobacco or alcohol consumption, is more effectively assessed by looking at trends in those disease processes with which they are most closely linked. While it must be borne in mind that the relationship between smoking and disease, as with many lifestyle factors, is characterised by long time-lags between exposure and outcome (sometimes many decades), the causal relationship between smoking and certain diseases is well established, leading to a growing body of research on smoking attributable disease.[197] Peto and colleagues have estimated that 12% of all deaths in Austria (i.e. 116 of every 1,000 deaths or, in total, roughly 9,000 deaths per year) are tobacco related.[7]

As noted in Chapter 6, the increase in smoking prevalence among youths in Austria (particularly among girls) and young women is of growing concern. In addition, there is a clear lack of information and education on possible health hazards resulting from smoking and, in particular, the risks associated with passive smoking. This chapter provides an overview of the health of the Austrian population and, in particular, the burden of disease attributable to smoking, including the harmful effects of passive smoking. It is one of the cornerstones of the later recommendations on the necessity of effective and comprehensive tobacco control policies in Austria.

7.2 Risk factors and burden of smoking-related disease

There is no doubt that tobacco damages human health. Furthermore, tobacco, and in particular cigarette smoking, has been recognised as the single largest avoidable cause of premature death and the most important known carcinogen to humans.[2] It is estimated that 25% of all cancer deaths and 15% of all deaths in the European Union could be attributed to smoking.[17] Among smokers in industrialised countries, the average loss of life is 8 years. Those who die in middle age have lost 22 years of their life on average.[5 6]

The relationship between smoking and certain diseases is complicated by the long delay between the onset of smoking and the occurrence of disease and, on the population level, a long delay between an increase in smoking rates within a population and the full effect on that popu-

lation's death rates from tobacco-related diseases.[198] Due to the high number of people who started to smoke many years ago, tobacco has created a major public health disaster in many countries of the developed world over recent decades, and it is emerging as a global public health disaster over the next few decades.[5] In addition, risks to smokers increase greatly the longer they smoke. This becomes especially important in view of the tendency to start smoking at an ever younger age.[199]

Tobacco smoke can contain over different 4,000 chemicals, including hundreds that are toxic, radioactive or carcinogenic[200 201] and of course including the alkaloid nicotine, an addictive compound that is a constituent of all tobacco products.[202] The highly addictive nature of nicotine may lead to addiction even after just starting to smoke.[96 203 204] More than 40 constituents of tobacco smoke are known to cause cancer, particularly tar.[6] Therefore, the direct health effects of tobacco consumption are two-fold. One effect is nicotine addiction (experts conclude that nicotine is as addictive as hard drugs, such as heroin, and that smoking meets both the DSM-IV and ICD-10 criteria for substance dependence[6 130]), another effect is the development of chronic diseases.

In addition to lung cancer, the health effect most closely associated with smoking, prolonged smoking causes many other diseases. For instance, smokers experience increased risks of heart attacks, strokes, and chronic respiratory diseases. They also have a significantly higher risk of developing cancers, both of organs that are directly exposed to smoke – such as the oral cavity (mouth, lips, tongue, etc.), oropharynx, oesophagus, larynx, and lungs – and of organs and tissues that are not directly exposed – such as the pancreas, bladder, kidney, stomach, cervix, and haematopoietic tissues.[2 205 206] According to a meta-analysis by Meltzer[207] in 1994, the most frequent tobacco-related diseases are cardiovascular diseases (acute myocardial infarction, diseases of the cerebrovascular system, peripheral arterial obstructive disease), cancer (particularly of the lungs), and diseases of the respiratory organs (e.g. chronic bronchitis and COPD). Very recently, an IARC (International Agency for Research on Cancer) working group added additional sites to the list of smoking-related cancers, including cancers of the stomach, liver, uterine cervix, and kidney (renal cell carcinoma) and myeloid leukaemia. In addition, so the findings of this group, the risks of developing some cancer sites increases when combined with exposure to other known carcinogens.[199]

Due to the variety of components, including thousands of chemicals, among them known poisons and carcinogens, tobacco smoking has proved to be a cause of multisystem disease.[208] Some of the components of tobacco and tobacco smoke damage blood vessels, others cause

cancer, but in summary they can harm almost every part of the body.[6] Altogether, nearly 40 diseases have been found so far to be positively associated with cigarette smoking.[209] The "major killers" are known to be coronary heart disease ('heart attacks'), chronic obstructive pulmonary disease (COPD), lung cancer and other smoking-related cancers.[6] The principal diseases caused in part by smoking are listed in Box 5.1: [2 6 199 208-214]

Box 7-1 Diseases caused in part by smoking

Principal diseases

Cancers

lung, mouth, pharynx, larynx, oesophagus, pancreas, bladder

Cardiovascular diseases

ischaemic heart disease, hypertension, myocardial degeneration, pulmonary heart disease, other heart disease, aortic aneurysm, peripheral vascular (arterial obstructive) disease, arteriosclerosis, cerebral vascular disease (stroke)

Respiratory diseases

chronic bronchitis and emphysema (chronic obstructive pulmonary disease, COPD), pulmonary tuberculosis, asthma, pneumonia, other respiratory diseases

Other major diseases

peptic ulcer

but also

Cancers

lip, nose, stomach, kidney (pelvis and body), liver, uterine cervix, myeloid leukaemia

Other harmful effects

reduced growth of foetus, Crohn's disease, osteoporosis, periodontitis, tobacco amblyopia, age-related macular degeneration, reduced fertility

some evidence

increased risk of

cataracts, impotence, reduced production of sperm

small increase in risk of

cancer in children as a result of mutations produced in the father's gonads

no evidence as yet

unaffected cancer risks

breast cancer, endometrial cancer, prostate cancer

Doll contends that the discovery of so many diseases being related to smoking is one of the most remarkable medical research findings of the 20th century.[209] Evidence of the harmful effects of smoking has been accumulating for 200 years, since the end of the 18th century, but it was not until the late 1920s, the 1930s and early 1940s with the publication of studies in Germany[215-220] and Austria[221] (although these studies were not known or essentially ignored in an-

glophone countries)[a] [117] [222] and then the 1950s with the publication of a number of case-control studies in the United States[b] and Britain that the relationship between smoking and lung cancer began to gain credence.[209] [223] Two large cohort studies followed, confirming the health hazards of smoking and particularly emphasizing the increased risk with duration of smoking. One was by Doll and Hill, on British doctors, which covered a 40-year period of observation[210] [224-226], confirming the enormous health impacts of tobacco on population health, and showing that overall mortality was twice as high in smokers as in non-smokers, and three times as high in middle age.[209] The other was the second American Cancer Society Cancer Prevention Study (CPS-II) observing a cohort of over 1.2 million adults, with comparisons with CPS-I, initiated 20 years earlier.[211] Similarly, an association between smoking by pregnant women and infant mortality, stillbirth and miscarriage was already reported from Germany in the late 1930s[117] and, although initially weak, an association between maternal smoking and premature delivery and low infant birth weight was reported from the United Kingdom and the United States in the late 1950s.[209]

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[a] Reports of the ill-effects of tobacco already exist from the times of the First World War (by the German military physician E. Beck), and a call to "all German Doctors" to combat smoking as both a cause of harm to the body and a financial drain on the German nation was published in 1921. In 1924, the Viennese gynaecologist Robert Hofstätter addressed the particular vulnerability of women who smoked and in 1938, Martin Stämmler argued that tobacco use by pregnant women was responsible for the growing incidence of stillbirth and miscarriage. The interference of smoking with male sexual performance was also reported as early as 1941. Various medical theses dealt with the health hazards of tobacco from as early as 1927.

The relationship between smoking and cancer of the mouth was already established in the 19th century, but it was Isaac Adler in 1912 who for the first time hinted at a link between smoking and lung cancer, and the German physician Fritz Lickint (Chemnitz, Dresden) who for the first time published statistical evidence (case series) connecting lung cancer and cigarettes in 1929 and subsequently published his monumental 1,100 page volume and standard work *Tabak und Organismus* (Tobacco and the organism) in 1939, linking smoking to cancers all along the *Rauchstrasse* ("smoke alley") lips, tongue, lining of the mouth, jaw, oesophagus, windpipe, and lungs, but blaming smoking also for arteriosclerosis, infant mortality, ulcers, halitosis, and dozens of other maladies.[220] He also compared tobacco addicts to morphine addicts and made a convincing argument that "passive smoking" (*Passivrauchen* – he seems to have coined the word) posed a serious threat to non-smokers.[117]

The Argentinean Angel H. Roffo, who published much of his work in German cancer journals, established a link between tars derived from tobacco smoke and cancer as early as 1930, and in 1935 Fritz Lickint stated that benzpyrene was more likely as a carcinogenic potency than nicotine. Neumann Wender of Vienna showed in 1933 that tobacco smoke contained not only tar and nicotine but also methyl alcohol and other toxins. In the same year, Enrico Ferrari of Trieste related tar to lung cancer.[117] Rudolf Fleckseder of Vienna reported on the relationship of smoking and lung cancer in 1936. In 1939, a paper by Franz Hermann Müller of Cologne, which presents the world's first controlled epidemiological study of the tobacco-lung cancer relationship[215], and in 1943 a paper by Eberhard Schairer and Erich Schöniger[216] provide the most sophisticated proofs up to that time for smoking as the major cause of lung cancer.[117]

In March 1939, 15,000 people attended a German conference (Frankfurt) on the hazards of tobacco and alcohol consumption. In 1941, there was scientific consensus in Germany that tobacco was behind the explosive rise in lung cancer.[117]

[b] It is thus hardly believable that German born and US immigrant Ernst Wynder, who was in Germany towards the end of World War II as a US intelligence officer, did not know about these studies when later (after a 1950 publication in the JAMA, together with E.A. Graham, on a case control study) being praised as the "first" to relate lung cancer to smoking. *(See Appendix S [Footnote b] and Appendix U.)*

Richard Doll describes the additional risk of lung cancer for smokers as varying from about 30% to double.[227] A recent review of epidemiological data on cancer by the IARC provides evidence that not only is the harm caused by smoking greater than previously thought – implicating tobacco in cancer sites not previously shown to be associated with smoking *(see above)* – but it also demonstrates that second-hand smoke causes an increased risk of cancer for non-smokers.[228 229] It is now beyond dispute (although still contended by the tobacco industry) that there are major health risks from passive smoking – for the foetus, for children of smokers, for life partners of smokers, and for all those exposed to passive smoking at their workplace *(Section 7.2.5 and Appendix L)*.

A Norwegian study [230 231] examined the influence of smoking on the duration of chronic disease before death. The follow-up study, covering 23 years, demonstrates that smokers, on an average, tend to develop chronic diseases nine years, and to die five years before non-smokers; on an average, they are ill for four years longer than non-smokers before they die.

As a result of the close association between smoking and a variety of diseases, in populations where smoking has been common for many decades, tobacco use accounts for a considerable proportion of mortality, as illustrated by estimates of smoking-attributable deaths in industrialised countries.[197] Estimates by WHO and other sources suggest that about half of persistent smokers who started in early adult life (not counting those who started already in childhood or adolescence) and who do not give up smoking will eventually die as a result of their smoking.[c] In addition, about half of them will die prematurely in middle age, before age seventy, losing on an average 20-25 years of life.[5 209 232]

Smoking has long been a serious public health problem in many European countries, and as more young people, teenagers and children have been taking up smoking in recent years, this will produce a marked increase in tobacco deaths over the next half century.[5] Especially among girls and young women, deaths can be expected to increase further, which is particularly worrying as, according to the US Surgeon General's Report on women and smoking [206], women are even more vulnerable to the health hazards of smoking *(Section 7.2.6 and Appendix L)*. In the developed world tobacco now accounts for about one-third of all male deaths in middle age.[8] For women, however, particularly in European countries, the epidemic has just begun, while in

[c] Although the main diseases developed by smoking are substantially different in various countries all over the world – for instance, America with a predominance of cardiovascular diseases, China with a predominance of chronic obstructive pulmonary disease, or India with increased risk of death from tuberculosis – the overall 50% risk of death from persistent smoking is estimated to be about the same in all populations.[5]

the United States tobacco-related mortality in middle age is already almost equal in men and women.[206]

7.2.1 Risk assessment

According to the WHO's World Health Report 2002, which focuses on risks to health as a key to preventing disease and injury, *risk* is defined as a "probability of an adverse outcome, or a factor that raises this probability". Accordingly, *risk assessment* is defined as a "systematic approach to estimating the burden of disease and injury due to different risks".[2]

Diseases are very often not caused by one single risk factor, but by the joint action of two or more risk factors (multi-causality). In addition, the sum of the separate contributions of two or more risk factors can easily be more than 100% (e.g. smoking and alcohol consumption). It is essential that the whole of the causal chain is considered in the assessment of risks to health. But just as one outcome can be caused by many risk factors, one risk factor can also lead to many outcomes. Similarly, a whole set of interventions can be employed to achieve the same goal (e.g. control of blood pressure, cigarette smoking and cholesterol to reduce cardiovascular disease) while some interventions will reduce the burden associated with multiple risk factors and diseases (e.g. interventions against cigarette smoking to reduce cancers and cardiovascular disease). In general, risk reduction strategies are more likely to be effective if based on a combination of interventions rather than just one.[2]

To assess risk and burden of disease within a population, standardised comparisons and common outcome measures are used. One common metric, for example, combines loss of quality of life with loss of life years, measured in DALYs (disability-adjusted life years) whereby one DALY is equal to the loss of one healthy life year. According to the WHO, tobacco is the leading risk factor in industrialised countries, accounting for about 12% of the total disease and injury burden, followed by alcohol and high blood pressure (9–10% of DALYs) and cholesterol and body mass (overweight) with 6–7% DALYs.[2]

Mortality attributable to smoking

In its World Health Report 2002, the World Health Organization differentiates between attributable versus avoidable burden of disease. Attributable burden is the current burden due to past exposure, while avoidable burden denotes the proportion of future burden that could be avoided if current and future exposure levels were reduced. To date, risk assessments have typically been based only on attributable risk estimates. More policy-relevant, however, is the question

of the likely future effects if the current exposure was partly removed. The difference between attributable and avoidable burden becomes especially important for exposures with a long time-lag between exposure and health outcome – as is the case with smoking.[2]

Attributable burden

About one third of all cancers can be attributed to smoking *(Box 7-1)*, as can a substantial amount of cardiovascular disease, as well as conditions such as peptic ulcer, low birth weight and sudden infant death. According to WHO estimates, approximately 90% of all lung diseases are tobacco-induced; for the development of several other diseases (e.g. cardiovascular diseases) the harmful components of smoking are seen to be at least partly responsible.[2]

For certain diseases the contribution of smoking to mortality is estimated to be up to 90% (e.g. lung cancer or cancer of the oral cavity). In its latest World Health Report, the WHO estimates that about one quarter of all deaths due to myocardial infarction as well as a substantial portion of diseases such as chronic bronchitis, peripheral circulatory disturbances – to name but a few – can be attributed to tobacco smoking. Deaths due to tobacco consumption exceed deaths due to illegal drug consumption by far.

Yet, it is difficult to assess the precise impact of smoking on health as other factors, such as diet, air pollution, dust and occupational harmful exposure also contribute to many smoking-related diseases. For example, smoking combined with alcohol consumption greatly increases the risk of oral and oesophageal cancer.[233-236] Air pollution and dust exposure at work can have additive effects to smoking in the development of chronic bronchitis.[237] Female smokers taking oral contraceptives have a higher risk of thrombosis, heart attacks, stroke or cerebral haemorrhage. [6 238 239]

But not only is active smoking harmful to the health of the smoker. As described in more detail later, passive smoking is also very harmful for both children and adults, healthy people and those who suffer from chronic disease, smokers and non-smokers alike *(Section 7.2.5 and Appendix L)*.

Avoidable burden

To assess the risk of future disease burden that could be avoided if adult smokers stopped smoking and young people did not start smoking, Peto and colleagues have estimated the potential scale of tobacco-related deaths worldwide over the next two to five decades.[8 210] According

to these projections, a high quitting rate over the next decade or two would halve global cigarette consumption per adult by the year 2020 and prevent about one third of tobacco deaths in 2020 and almost one half of tobacco deaths before 2050. If, on the other hand, the proportion of young adults who become smokers were to be halved by 2020, this would avoid hundreds of millions of deaths from tobacco worldwide after 2050. It would, however, avoid very few of the millions of tobacco-related deaths in the first quarter of the century, and avoid only a relatively small proportion of the deaths from tobacco in the second quarter of the century. These calculations show that quitting by adult smokers (preferably before or at least in middle age) offers the only realistic way to prevent large numbers of tobacco deaths over the next half century, while helping large numbers of young people not to become smokers could avoid millions of tobacco deaths in the second half of the century.[5] Therefore, to achieve substantial changes in smoking behaviour, both strategies are needed: getting adult smokers to quit and preventing children, teenagers and young people from starting smoking.

The following section will examine smoking-related morbidity and smoking-attributable mortality in Austria.

7.2.2 Smoking-related mortality in Austria

In Austria, according to the most recent country-specific estimates of Peto and colleagues[7], roughly 9,000 individuals[d] die as a consequence of smoking every year, i.e. one in eight adult deaths. According to estimates of the Austrian Social Insurance Funds and the Institute of Social Medicine of the University of Vienna, 15 to 20 percent of the annual expenditure on health care in Austria may be accounted for by the treatment of diseases primarily due to smoking (such as cancer, cardiovascular diseases, chronic lung diseases). The yearly smoking-related healthcare costs to the social insurance funds are estimated to be €1.5 to 2 billion.[240 241]

To overcome the lack of data on smoking in many countries, Peto and colleagues used lung cancer mortality rates to estimate smoking attributable mortality as a measure of population exposure to tobacco.[8] This approach estimates indirectly the mortality from tobacco in developed countries by assuming that the excess lung cancer rate of smokers compared to non-smokers in a population is the best indicator of cumulative population exposure to smoking hazards; so the absolute lung cancer rate in a particular population is used as an indicator of the proportion of deaths from various other diseases that can be attributed to smoking.[242] According

[d] Previous estimates by the WHO, as still cited by the Federation of Austrian Social Insurance Institutions and Austrian health politicians, report 12,000 to 14,000 individuals.

to these estimates by Peto, Lopez *et al.* (last updated 2003[7]), the effects of smoking can particularly be seen in smoking-related deaths in middle age (35 to 69 years). In Austria, the mean years lost per death from smoking was 23 years in this age-group in 2000 *(Table 7-1)*. The proportion of smoking-related deaths within all cancers was 41% for men and 13% for women *(Table 7-2)* and the number of smoking-attributed deaths amounted to 3,200 in middle-aged men and 700 in middle-aged women in 2000, representing 26% (male) or 12% (female), respectively, of all deaths in this age-group *(Table 7-2 and Figure* 7.1*)*. Among all ages, smoking-attributable deaths in 2000 amounted to 6,300 among men and 2,600 among women, representing 18% (male) and 6% (female), respectively, of all deaths. The estimated share of mortality attributable to smoking is shown in Figure 7.1. The clear decrease in mortality in men and the marked increase in women is apparent.

Table 7-1 Relative importance of deaths in middle age (35–69 years), Austria 2000

Age range (years)	Deaths attributed to smoking / total deaths (thousands)		Mean years lost per death from smoking
	Male	Female	
0–34	– / 1.4	– / 0.6	–
35–69	3.2 / 12	0.7 / 6.3	**23 years**
70+	3.2 / 22	1.8 / 35	8 years
All ages	6.3 / 35	2.6 / 42	15 years

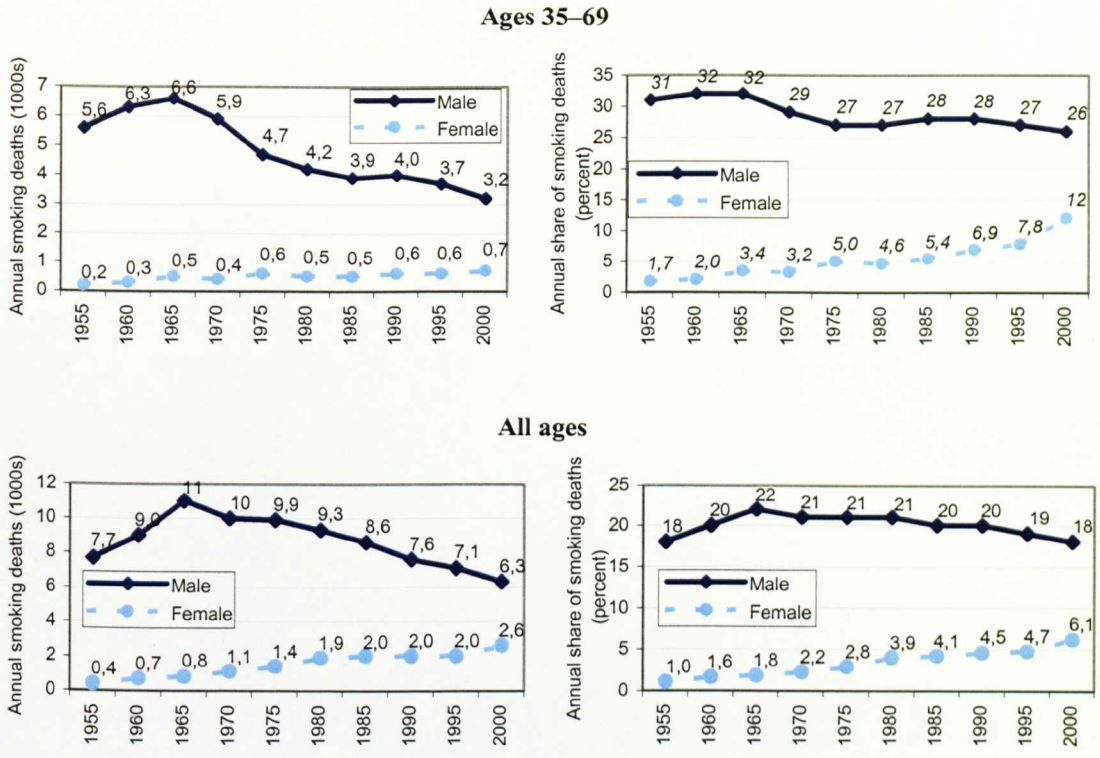
Source: PETO, LOPEZ et al. 2003.[7]

Table 7-2 Numbers of deaths attributed to smoking / total deaths (thousands), Austria 2000

Cause	Males (by age)			Females (by age)		
	0-34	35-69	70+	0-34	35-69	70+
Lung cancer	–/0.0	1.1/1.2	0.9/1.1	–/0.0	0.3/0.4	0.3/0.5
All cancer	–/0.1	1.7/4.1 *(41%)*	1.4/5.3 *(26%)*	–/0.1	0.4/3.0 *(13%)*	0.5/6.2 *(7%)*
Vascular	–/0.1	1.0/4.2	1.0/12	–/0.1	0.2/1.7	0.8/22
Respiratory	–/0.0	0.3/0.5	0.6/1.5	–/0.0	0.1/0.2	0.5/1.9
All other	–/1.2	0.3/3.4	0.2/2.8	–/0.5	0.1/1.4	0.1/4.5
All causes	–/1.4	3.2/12 *(26%)*	3.2/22 *(15%)*	–/0.6	0.7/6.3 *(12%)*	1.8/35 *(5%)*

Source: PETO, LOPEZ et al. 2003.[7]

Figure 7.1 Smoking-attributed deaths: thousands per year and percent of all deaths. Austria 1955–2000



Source: *PETO, LOPEZ et al. 2003.*[7]

Given the nature of the relationship between smoking and lung cancer, this cause of death seems to be the best marker for smoking-related mortality and will therefore be looked at more closely. Cardiovascular diseases, although less appropriate as a marker than lung cancer, as they are also attributable to other risk factors, also play an important role in the overall total of smoking-related diseases and deaths and are discussed in Appendix L.

7.2.3 Cancer (incidence and mortality) in Austria

About one third of all cancers can be attributed to smoking. Besides the lungs, the organs most affected by smoking are oral cavity, lips, pharynx, larynx, trachea, oesophagus, bladder, kidneys, pancreas and stomach.[2 199 205 209-212] Although all of these cancers have causes other than just smoking, cancer of the respiratory system including oral cavity (ICD-9 140-149, 160-165), oesophagus (ICD-9 150), stomach (ICD-9 151), pancreas (ICD-9 157) and urinary tract (ICD-9 188, 189) accounted for 51% (male) and 32% (female) of all cancers in Austria in 2001.[243]

However, lung cancer accounts for the greatest share of cancer directly related to smoking, although the proportion of male deaths resulting from cancer of the lips, oral cavity and throat (e.g. cancer of the tongue, etc.) should not be underestimated. In Austria, more than 3,000 people die of lung cancer every year, i.e. one in six (17.3% in 2001) of all cancer deaths or 4.3% of all deaths, respectively.

Lung cancer (including bronchi and trachea)

Malignant neoplasms of the trachea, bronchi and lungs (ICD-9 162) are the most common cancers attributable to smoking. According to WHO- and other estimates[2 8 209], approximately 90% of all lung diseases are tobacco-induced. The actual development of the disease is preceded by many years of tobacco consumption. Thus the peak incidence is only reached at about 50 to 60 years of age.

The increased consumption of low-tar, "light" cigarettes (often related with an increase in the quantity of cigarettes and deeper inhaling of the smoke, called "compensation") is already being reflected in the types of lung carcinoma encountered: while earlier cancers tended to be central, cancer is increasingly likely to arise in the peripheries of the lungs.[a 126]

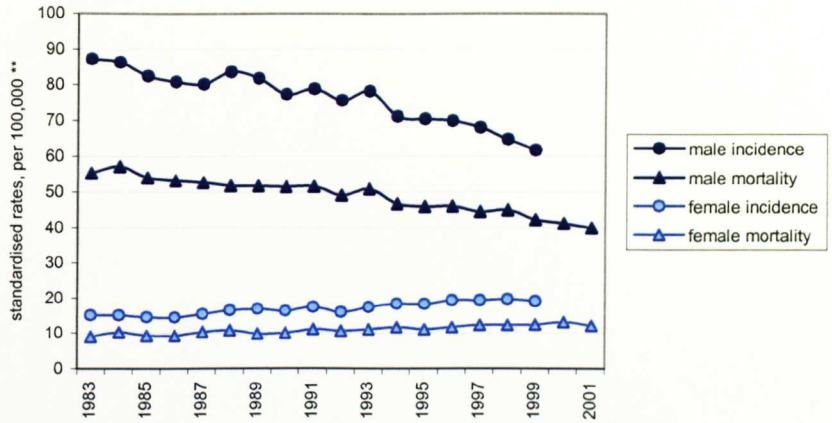
Incidence and mortality

Over the last two decades, after a peak in incidence among men in 1993, a marked downward trend in lung cancer has been observed for men *(Figure 7.2)*. Between 1993 and 1999, the latest year for which data were available, incidence fell by more than 20%. In women, on the contrary, there has been an increase in incidence of more than 17% between 1990 and 1999. This is consistent with the rising rate of female smoking since the early 1970s *(see below)*, a phenomenon that can be expected to lead to further increases over future decades.

In 1999, 3,602 persons – 70% of them men – developed lung cancer. This corresponds to an age-standardised incidence rate of 61.6 per 100,000 for men compared to 19.0 per 100,000 for women.[243]

a According to Christian Vutuc (Vienna University Cancer Research Institute) a clear shift in the localisation of lung cancer is observable over the last decades. While in the 1970s, 11% of carcinomas were peripheral, in 1990, it was already 28%. Today, this figure amounts to 57%.[126]

Figure 7.2 Lung cancer. Age-standardised incidence- and mortality rates by sex, Austria 1983–2001*



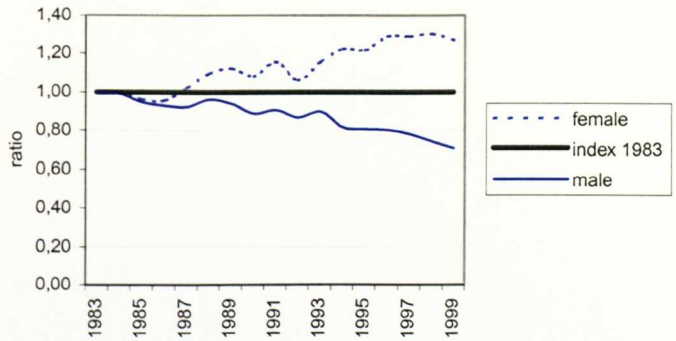
* Cancer incidence: latest available year under review 1999.

** Age-standardisation based on European standard population (World Health Statistics Annual 2001, online version).[43]

Source: Statistics Austria – cancer registry and mortality statistics.[243]

Male mortality from lung cancer fell significantly over the last two decades; between 1983 and 2001 it dropped by –28%. Over the last decade, however, the decrease was especially marked (–22.5% between 1991 and 2001). Still, lung cancer constitutes the second most frequent type of cancer (after intestinal carcinoma) in Austrian men. In women, consistent with the increase in lung cancer incidence, lung cancer mortality is on the rise, increasing by 35% between 1983 and 1999. In 1999, 19.0 of 100,000 Austrian women (age-standardised) were diagnosed with lung cancer and 12.0 of 100,000 women died of this type of cancer *(Figure 7.3)*.[243] While the risk of developing lung cancer remains disproportionately higher for men, the female to male ratio dropped from 1:4.9 to 1:3.2 over the past decade (1989 to 1999). This marked increase in female lung cancer can be interpreted as a consequence of the growing share of female smokers in the population. With regard to mortality, the female to male ratio dropped from 1:4.7 in 1991 to 1:3.3 in 2001.

Figure 7.3 Lung cancer incidence, relative development by sex, Austria 1983–1999



Source: Statistics Austria – cancer registry[243]*; own computations. Standard population: World Health Statistics Annual 2001, online version*[43].

In conclusion, one can say that the incidence rate as well as the mortality rate is more than three times as high in men as in women and, although still very high, male mortality rates are decreasing while female rates are rising slightly.

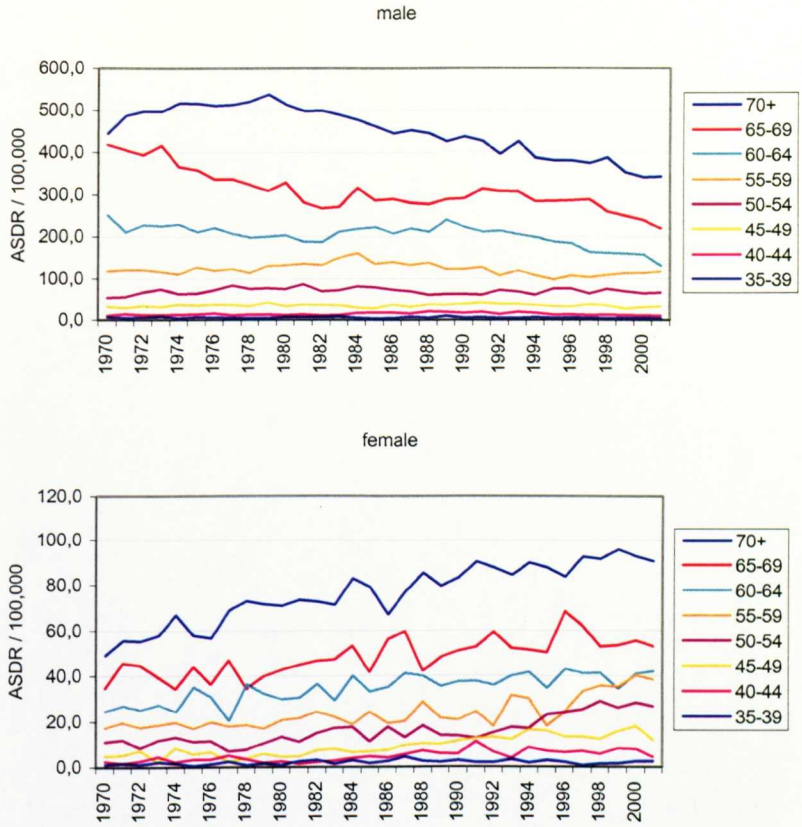
Age-specific lung cancer mortality

Standardised death rates for lung cancer were calculated by direct standardisation for every year from 1970 to 2001 and for age groups in five-year bands. The reference population was the European standard population *(Chapter 2; 2.2.3)*.[244]

In total, and disregarding minor fluctuations, the trends in age-specific lung cancer mortality confirm what has been already reported in the general analysis. While for men mortality rates are clearly decreasing, particularly in the age groups 60 years and over, women show a slow but continuous increase in mortality rates in all age groups. A notable increase in female lung cancer mortality can be observed between 1995 and 2001 for the ages 50 to 59 years. This seems to reflect a cohort effect among those born between 1940 and 1950, who as young adults experienced the economic recovery in the late 1950s and 1960s and the women's liberation movements in the late 1960s and 1970s *(see below)*.

Although there are still clear differences in lung cancer mortality between men and women, this reversal of trends has led to an increasing equalisation of age-specific mortality rates between the sexes *(Figure 7.4)*.

Figure 7.4 Age specific lung cancer mortality in Austria 1970-2001, by sex (N.B. different scales)

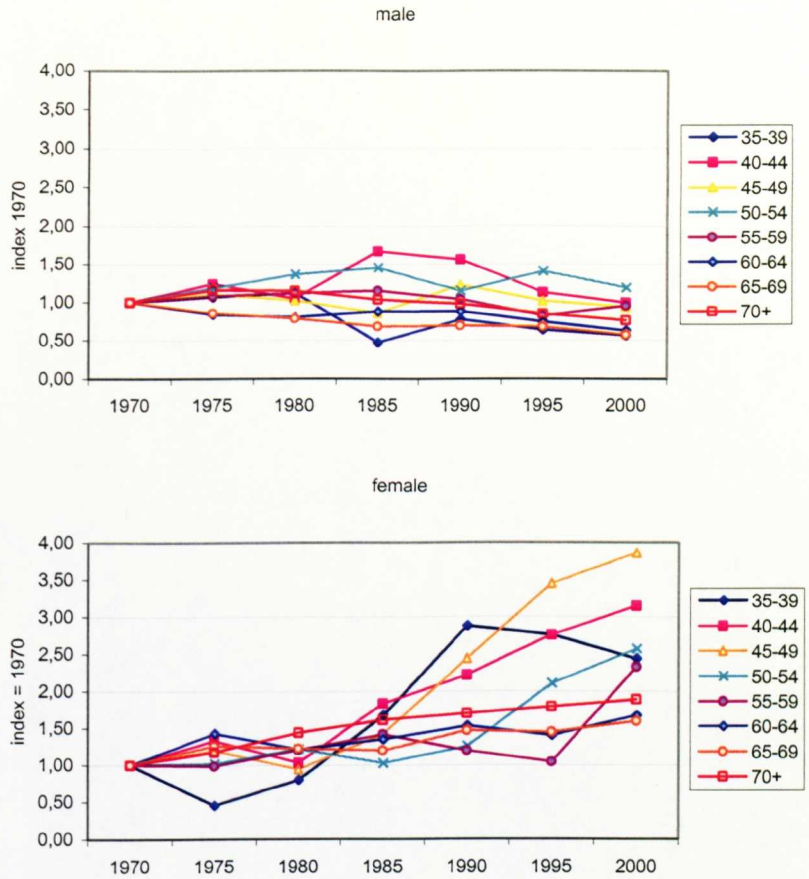


Source: Statistics Austria – mortality statistics (crude data)[245]; own computations. Standard population: World Health Statistics Annual 2001, online version[43].

Figure 7.5, which shows the relative mortality over the last three decades, illustrates this development even better.[b]

[b] To maintain the five-year gaps, 2000 was chosen as last year of reference.

Figure 7.5 Relative lung cancer mortality by age groups (5 year bands) in Austria, 1970–2000, by sex

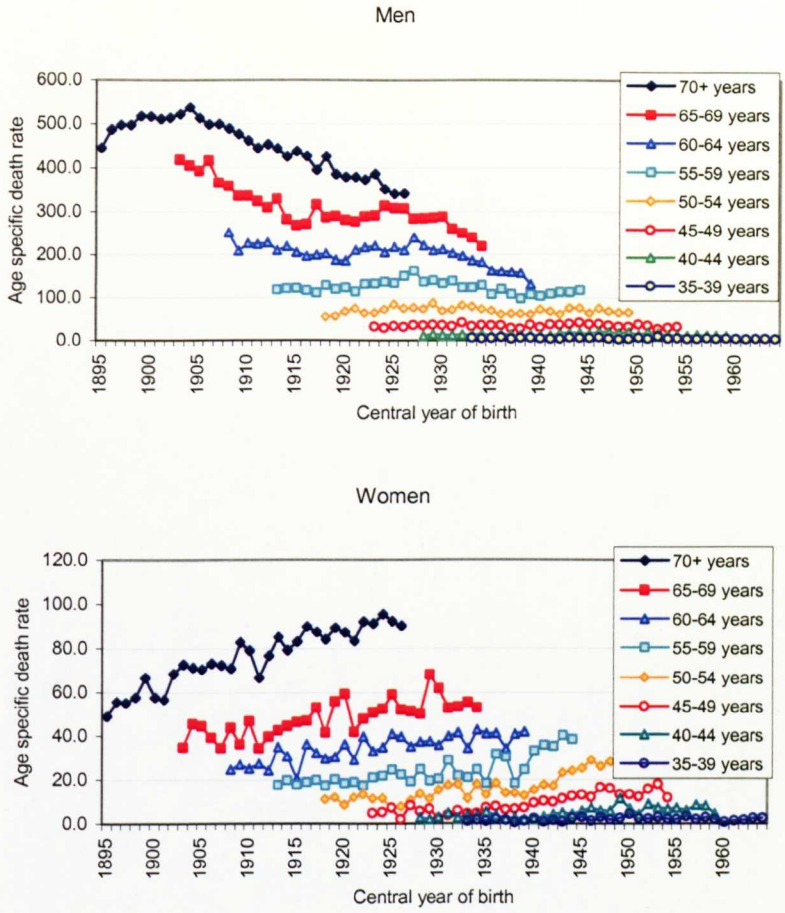


Source: Statistics Austria – mortality statistics (crude data)[245]*; own computations. Standard population: World Health Statistics Annual 2001, online version*[43].

Cohort analysis

A cohort analysis of lung cancer mortality makes these findings even clearer. The analysis is based on yearly standardised death rates[245] for age groups in five-year bands, starting at age 35 and covering the period 1970 to 2000 (year of death). In a second step, the central year of birth was calculated for every age group and for every year of death. For example, those who died in 1970 aged 35 to 39 years were born between 1931 and 1935; the central year of birth for this cohort was assumed to be 1933. Accordingly, those who died in 1971 (the same age group) were born between 1932 and 1936 and the central year of birth was calculated to be 1934. Figure 7.6 below will illustrate more clearly the procedures and the associations revealed between birth cohorts and lung cancer mortality.

Figure 7.6 Lung cancer mortality by birth cohorts and age groups in Austria, 1970–2000, by sex (N.B. different scales) *



* As the female rates are markedly lower than the male, different scales were chosen. A direct comparison of the two graphs is therefore not possible.

Source: Statistics Austria (crude data)[245]; own computations.

Cohort effects are the manifestation of influences acting on individuals at different stages in their life. For social, cultural and economic reasons, smoking was generally initiated at a later age at the beginning of the 20th century than at the end.[11] There are, of course, also gender-specific differences. While the main increase in cigarette smoking among young men took place during the first half of the 20th century, women increasingly started to smoke during the second half of the century.[5] In Austria, however, this increase in female smoking was even longer delayed than, for example, in the United Kingdom or the United States.[11]

Within the male population, a noticeable peak in lung cancer mortality is visible in those born between 1899 and 1905. This is the cohort that experienced the First World War (1914–1918) as adolescents or young adults. Contemporary accounts describe how, during war times, ciga-

rettes have been distributed freely to soldiers by many governments.[117] World War I occurred soon after mass production of cigarettes had begun and is particularly well-known for the widespread distribution and popularisation of cigarettes; smoking among young men in industrial countries began to increase dramatically.[246] With nicotine serving as a psychotropic agent, cigarettes had a relaxing effect, repressing fatigue, weariness, feelings of hunger, and helping establish contacts. Almost all soldiers smoked. During World War II, the consumption of cigarettes quadrupled worldwide.[246 247] It may, therefore, be assumed that for many young men the foundation of a prolonged smoking career was laid then. Similarly, although to a lesser degree than with World War I, the effects of the Second World War on male lung cancer mortality are visible in this cohort analysis *(Figure 7.6)*. In addition, with a time lag following developments in the United States, the active marketing of cigarettes after World War II showed marked results in tobacco consumption in the beginning of the second half of the twentieth century.[246 248] *(Appendices C and R)*.

Compared to previous birth cohorts, a clear decrease in age-specific mortality rates can be seen in those men born at the beginning or in the middle of the 1930s. As with those who experienced the depression between 1930 and 1935 as young adults, the vulnerable period for this cohort fell in the post-war period when tobacco products were simply not affordable for most young people, leading to an imposed abstinence from tobacco *(Appendix R)*.[45] At later ages there was less interest in starting smoking. However this decrease in lung cancer mortality applies only to the age groups from 50 years onwards. The earlier experience of lung cancer mortality in this cohort does not follow any consistent pattern, in part it even shows an increase. It is possible that, with these early deaths, other reasons than smoking might be decisive – as for instance, environmental factors such as asbestos at the workplace[c].[126]

For women, apart from the general trend of a slow but continuous increase in lung cancer mortality and a noticeable peak in lung cancer mortality in the birth cohort from 1925 to 1930, a particularly pronounced increase can be observed in those born between 1940 and 1945. (In men, this trend is also seen, but to a lesser degree.) The main reason for the increasing uptake of smoking among women was the new marketing strategy adopted by the tobacco industry, emphasising modern, independent women, and the manufacture of brands specifically targeted towards females. Although increasing cigarette consumption cannot be linked precisely with

[c] Although, according to documents of the tobacco industry from the 1970s, studies from the United States could show that 97% of the asbestos workers who died of lung cancer were smokers (RJR 500872076, memo by E. Brueckner of the German Verband[120]) – thus allowing the industry to point "safely" at the risks of occupational diseases.

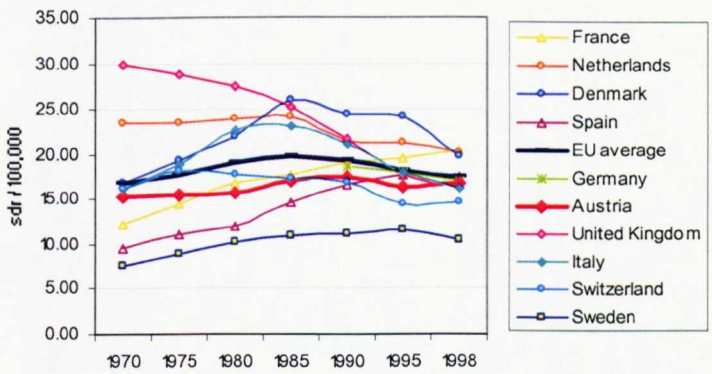
trends in economic development (level of industrialisation or per capita income)[246], these birth cohorts also enjoyed the period of economic recovery that started at the end of the 1950s. At least it made it more affordable to respond to cigarette advertisements, particularly for the young. The clear increase in age-specific mortality rates continued in females born between 1945 and 1950. This cohort might have been influenced by the feminist movement of the late 1960s and 1970s. As with men, early lung cancer mortality among women follows only partly the trend seen at older ages, with a possible added factor being the relatively low numbers.

The increase in mortality in this birth cohort (1945 to 1950), although also in the younger age groups, can also be observed in a cohort analysis in west Germany.[249]

Lung cancer in a European comparison

While in other countries, such as the United Kingdom, Denmark, or Spain, a rather spectacular decrease in lung cancer mortality has been identifiable since the mid 1980s, the development in Austria is rather continuous and no evidence of a consistent decrease is as yet visible for both sexes combined. Until the early 1980s, the Austrian values were somewhat below the European average. Since then, however, the gap has been decreasing with the decline of the value of the European average *(Figure 7.7)*.[250]

Figure 7.7 Development of lung cancer mortality in selected European countries* and EU average, ages 0-64 years, 1970–1998, standardised rates**



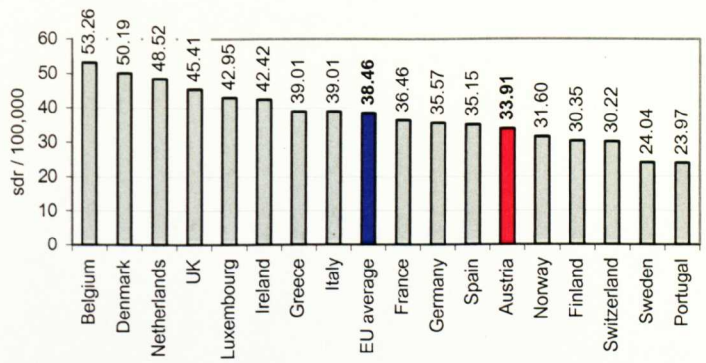
* Including the western neighbour country Switzerland.

** Unequal intervals, as due to incomplete availability of data 1998 was selected as year of reference (Switzerland: 1997).

Source: WHO – Health for All database, last update January 2002.[250]

In a ranking of all EU member states plus Switzerland and Norway, Austria still lies below European average in 1998 *(Figure 7.8)*.[250]

Figure 7.8 Trachea, bronchi and lung cancer mortality in Europe* 1998, all ages, standardised rates



* EU member states plus Switzerland and Norway.

Source: *WHO – Health for All database, last update January 2002.*[250]

7.2.4 Other smoking-related diseases

Other smoking-related diseases include cancer of the upper respiratory tract (oral cavity, lips, pharynx, larynx) and oesophagus *(Appendix L)*, but also asthma, bronchitis, respiratory infections, and chronic obstructive pulmonary disease (COPD).[2 130 206 209 212] In most industrialised countries COPD is one of the three major killers in adult life.[6] In Austria, about 400,000 persons are estimated to suffer from COPD, representing 5% of the whole population or more than 10% of over 40 year olds, although this is likely to be an underestimate. 90% of sufferers are reported to be smokers, most aged 40 years and over.[251] According to the European Lung White Book[252] the risk of COPD in smokers compared to non-smokers is sixfold higher. For Austria, though, there are no relevant studies.[253]

There is a lack of representative statistics on the incidence of other smoking-related diseases, in particular as related to the individual's smoking behaviour, so no data for Austria can be given here. The 1999 microcensus on health asks about difficulties in breathing and 3.8 per 1,000 men and 4.0 per 1,000 women stated they suffered from one of these ailments.[254]

International comparisons of overall mortality data from bronchitis, emphysema, and asthma are problematic, in particular because of different national coding traditions for deaths at old age where multiple processes are present.

7.2.5 Diseases related to passive smoking

Although important for the discussion of smoking bans in public places, due to limited space, discussion of diseases related to passive smoking has had to be shifted to the Appendices. In this context, therefore, only an overview in the form of Box 7-2 can be given. For a more detailed description please refer to Appendix L.

Box 7-2 Health effects associated with exposure to environmental tobacco smoke (ETS)[255]

Effects causally associated with ETS exposure

Developmental effects
- Foetal growth: low birth-weight or small for gestational age
- Sudden infant death syndrome (SIDS)

Respiratory effects
- Acute lower respiratory tract infections in children (e.g. bronchitis and pneumonia)
- Asthma induction and exacerbation in children
- Chronic respiratory symptoms in children
- Eye and nasal irritation in adults
- Middle ear infections in children

Carcinogenic effects
- Lung cancer
- Nasal sinus cancer

Cardiovascular effects
- Heart disease mortality
- Acute and chronic coronary heart disease morbidity

Effects with suggestive evidence of a causal association with ETS exposure

Developmental effects
- Spontaneous abortion
- Adverse impact on cognition and behaviour

Respiratory effects
- Exacerbation of cystic fibrosis
- Decreased pulmonary function

Carcinogenic effects
- Cervical cancer

In Austria it is estimated that every year about 1,400 people die as a consequence of the smoking of others.[256]

7.2.6 Women and smoking

Women not only feel more disturbed and harassed by the smoking of others *(Chapter 6; Appendix K)*, they are also more vulnerable to health hazards from both active and passive smoking. In addition, the issue of female smoking is becoming ever more important in view of the increasing smoking prevalence rates among girls and women in nearly all countries in both the developed and less developed world. Women are also actively targeted by the tobacco industry's marketing strategies, associating social desirability and independence and featuring slim, attractive, athletic models in their advertisements.[4 206] A study of young female adolescents indicates that the importance placed on being slim predicts future smoking initiation.[257] Tobacco companies have also produced brands specifically designed for women.

The issue of ETS becomes particularly important in view of the fact that, although the majority of women are non-smokers, many non-smoking women have a smoking partner, resulting in a life-long exposure to ETS in their homes. The increased incidence of lung cancer in wives of heavy smokers was already reported two decades ago[258 259], and more recently particularly by Fontham and others[260], Jarvis and others[261], and the review by Hackshaw[262]. According to the epidemiological studies reviewed, women who are lifelong non-smokers have a statistically significant excess risk of developing lung cancer (24%, CI 95%) if exposed to ETS by their spouse, increasing with the number of cigarettes smoked and duration of marriage.[262] If these women, who are already exposed to passive smoke in their homes, are additionally exposed to ETS in their workplace, their risk increases even further. According to the Fontham study, women who do not smoke and who have never smoked face a 30% greater risk of developing lung cancer if their husbands smoke in the home, a 39% greater risk of lung cancer if they are exposed to second-hand smoke in the workplace, and a 50% greater chance of lung cancer if they are in social settings.[260]

For more studies on women and smoking please see Appendix L.

7.2.7 Smoking cessation

No matter at what age one stops, smoking cessation decreases health risks.[263] Some excess risks due to smoking are significantly reduced within a very short time *(please see Appendix L)*.

7.3 Conclusion

In Austria, currently 11.6% of all deaths are attributed to smoking. For Austrian men, however, this rate is markedly higher than for Austrian women. For 18% of all male deaths and 6.2% of female deaths the cause of death is related to their prolonged previous smoking.[7] As in many other western European countries, smoking-attributable death-rates are decreasing significantly in Austrian men and increasing markedly in Austrian women.

About half of the persistent smokers (those who start young and do not give up) will die as a result of their smoking and half of them (i.e. a quarter of all smokers) will die in their middle age, losing on average about 20-25 years of life.[5]

The predominant diseases attributable to prolonged smoking are lung cancer and cardiovascular diseases, in particular increased risk of heart attacks and strokes. In general, smokers have a greater risk of developing cancers, both of organs that are directly connected to smoking – such as oral cavity, pharynx, larynx, oesophagus, and of course lungs – and of organs and tissues that are not directly connected to smoking – such as the pancreas, urinary track, kidney, stomach, and haematopoietic tissues. In addition, women experience specific risks related to reproductive health. In pregnancy, smoking increases the risk of adverse birth outcomes.[2 206]

A cohort analysis of lung cancer mortality of Austrian men and women shows the impact of events, in particular both world wars for men and the feminist movement for women, on smoking behaviour.

Smoking not only harms consumers, but also people exposed to their smoke. Over the last 20 years or so epidemiological evidence as to the harmful effects of environmental tobacco smoke (ETS) to non-smokers has accumulated and exposure to ETS has been linked to a variety of adverse health outcomes. ETS is harmful to all who are exposed to it, but especially harmful to children, people with respiratory and heart problems, and pregnant women. It also has significant effects on hospitality employees who are exposed to ETS continuously and for many hours every day.

Giving up smoking would reduce the excess risk of many diseases relatively quickly, and the promotion of cessation would benefit not only the health of the ex-smoking individual and all non-smoking individuals, including children, around him, but also significantly reduce the enormous excess health care costs for smokers.

Despite all these findings and more active approaches in other European countries, in Austria public awareness is still very low to non-existent, and legislation on smoke-free environments is still rather weak. However, in view of the serious health consequences and the high prevalence of cigarette smoking in the population, the enormous negative impact on public health should be sufficient to justify measures to restrict smoking in all public places and workplaces, and to discourage people from smoking in their homes.[262 264] In the words of Hackshaw: "Passive smoking is an avoidable cause of mortality and morbidity. Prevention strategies to reduce the amount of cigarette smoking in public places should be part of public health policy".[262]

The following chapter will examine the measures taken by the Austrian government to restrict smoking in public places and reduce smoking rates in the population.

8 ANTI-SMOKING MEASURES IN AUSTRIA – A CRITICAL ANALYSIS

8.1 Introduction

Chapters 3, 4 and 5 have explored the various frameworks that can be used to understand tobacco policy, the forces driving that policy, and assessed the overall effectiveness of tobacco control measures. This chapter expands on these findings and attempts to apply these frameworks to the situation in Austria. It focuses on the current status of its tobacco control policy, provides an overview of initiatives taken over the last two decades, and assesses its overall approach to tobacco control.

Among western European countries, Austria has been found to be the "smoker-friendliest" country[265], priding itself on its "tradition of tolerance" (i.e. at least in the matter of tobacco and alcohol). A recent study conducted in EU countries, plus Poland, distinguished Austria as having the least developed anti-smoking climate, with Germany almost equally bad. In contrast, Poland showed the most developed anti-smoking climate, closely followed by Sweden.[1]

Austria's legal situation is characterised by weak laws with little provision for enforcement and virtually no sanctions. It is not surprising that adherence is poor. Therapeutic support for those willing to quit is still very limited and often handled unprofessionally. A lack of information or educational measures is reflected in the poorly developed public awareness about smoking in public places and the smoking-related health hazards to both smokers and non-smokers. The issue of environmental tobacco smoke in the workplace, including restaurants, pubs and bars, is not yet on the political agenda or subject to public discussion. Although Austria's EU entry in 1995 led to regulations on smoking in the workplace, this law is rather weak and noncommittal, even after two recent amendments designed to strengthen it. The issue of smoking in restaurants, pubs and bars has been cautiously tackled by a small part of the diminutive Austrian public health community over recent years but has not penetrated the political agenda, nor has it attracted media interest. The public is therefore mostly unaware of any concern. Equally, the issue of reduction of the toll of premature death from smoking-related disease is not a key element of Austrian health policy.

Although the government is not inactive in its efforts to tackle smoking, almost all of the few measures taken are those which have been shown to be not at all or hardly effective, or even

counter-effective. In addition, those feeling harassed by the smoking of others and favouring restrictions on smoking consider themselves as a minority and are not organised. Generally, non-smokers in Austria have been very reluctant to express or assert their rights, often not even knowing that they have rights. Although the employees' protection act regulates smoking in the workplace, the approach of 'voluntary agreement' between employers and employees is predominant and complaints are rarely, if ever, brought to court as this would often be tantamount to losing one's job.

Using the ESTC framework, outlined in Chapter 5, this chapter examines tobacco control measures in Austria with regard to legislation, taxation and pricing, advertising, education, campaigning and support offered for those who want to quit smoking. Smuggling and youth access are also addressed. Present and past measures and policies are described, asking why some measures have been adopted and others not. Since Austria has become a member of the European Union in 1995, its tobacco control policy must be seen within the wider European political and legislative framework. However, while other countries are already far ahead of the requirements stipulated in the European Commission's recent directives on tobacco control *(Chapter 4)*, for Austria these minimum requirements may be seen as a chance to stimulate and accelerate measures that otherwise would not have been set.

8.2 Concept and rationale of Austrian tobacco control policies

8.2.1 Implementation of EU legislation

Austria is in conformity with EU legislation but does not go beyond it. Considering that, for example, the advertising and sponsorship directive 2003/33/EC sets only the minimum standard that the European countries could agree upon, it is noteworthy that even these minimum requirements are met only very reluctantly and 'at the last minute', and are widely seen as "too extreme". In August 2003, the European Commission sent "reasoned opinions" to the governments of Austria, Italy and Luxembourg over their failure to implement the tobacco products directive 2001/37/EC.[266] They should have done so by 30 September 2002 at the latest. Only as late as September 2003, after this rebuke from Brussels[267] and the threat of taking the Austrian government to the European Court of Justice, were larger warning labels placed on cigarette packs and terms such as "light" or "mild" excluded, one year later than they should have been. The reason for this delay, so the Health Ministry reports, was the premature termination of the Federal Government following elections in 2002. Given the federal legislative system in Aus-

tria, this excuse has been accepted by the European Commission.[268] *Austria Tabak*, on the other hand, had claimed the reason lay with the paper industry and the prolonged time required for conversion.[269] In reality, it seems more likely that this delay can be ascribed to a lack of political will to implement any restrictions on tobacco. This is also evident in the latest amendments of the already weak 1995 tobacco law. The 2001 amendment (BGBl. I Nr. 98/2001) only concerned the substitution of Euro for Schillings of fines for violations of advertising restrictions[30] (which now, because of the regulation that all fines established in Austrian legislation had to be rounded down, are even less than in 1995[a]). In any case, these fines certainly do not pose a threat to the tobacco industry and, as no-one takes responsibility to enforce this regulation, it is a purely theoretical matter. The latest amendment in 2003 (BGBl. I Nr. 74/2003), took EU law formally into national law, but adopting only the absolute minimum requirements.

Austria may therefore be described as one of those member states with a very weak stand on tobacco control. It does not even "hide behind the European position"[27], but, at least "at home", complacently distances itself from this "extreme" position *(Chapter 9)*.

8.2.2 Tobacco control plans

Effective national tobacco control programmes are multisectoral and comprehensive, linked to specific targets and implemented by a designated body. The Warsaw declaration and the resulting ESTC resolution urged the WHO's Member States to draw up national action plans on tobacco.[61]

The current implementation status of tobacco control policies in the various WHO member states differs widely. In 2001, approximately half of WHO's European Member States had national action plans and three quarters had intersectoral coordinating bodies, but only half had both. Austria had neither a national tobacco control action plan, nor specific targets on tobacco, nor a national coordinating body for tobacco control. At the end of 2001, Austria, Belgium, Germany and Greece were the only countries in the EU region without a tobacco control plan.[b] The status in Austria in 2003, compared with the most recent overview of Europe as a whole (2001)[132 270] is shown in the following table.

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[a] The correct amount after conversion would have been €7,267 instead of €7,000, and €14,535 instead of 14,000.

[b] For comparison (although limitations of these statistics have to be borne in mind), Armenia, Azerbaijan, Bosnia and Herzegovina, Denmark, Finland, France, Georgia, Iceland, Ireland, Lithuania, the Netherlands, Norway, Poland, Portugal, the Russian Federation, Slovakia, Slovenia, Spain, Sweden, the former Yugoslav Republic of Macedonia, Turkey, and the United Kingdom had all three of them, and many other countries had at least two of these important elements of a comprehensive tobacco control policy.[61]

Table 8-1 Implementation of a comprehensive tobacco control policy, status at end of 2003

WHO EUROPEAN MEMBER STATES: 2001	AUSTRIA: 2003
Only half of all European member states had drawn up national action plans.	Austria has been far from having a tobacco plan as yet.
Only half of all countries had introduced partial restrictions or total bans on both direct and indirect forms of advertising of tobacco products.	Austria has had only partial restrictions on advertising in cinemas (in films aimed at youth) and a complete advertising ban in television and domestic print media.
Only one third of all countries had sustainable and gender-based public information campaigns.	Austria has been focusing exclusively on teenagers over the last couple of years, by launching or supporting some (mostly ineffective) youth-oriented anti-smoking campaigns.
Under one quarter had earmarked tobacco taxes.	Tobacco taxes in Austria are not earmarked; however, in 2002 a small proportion of the tobacco tax revenues were dedicated to the Federation of Austrian Social Insurance Institutions (uncommitted, however, but aimed to minimise the overall deficit). In September 2003, the use of part of this amount for a more comprehensive voluntary screening test programme was under discussion, but ceased again. In addition, a certain percentage of the income purchase taxes of tobacco products are used to finance the Fund for a Healthy Austria, a government funded institution for national health promotion activities. However, only a very small part of this money is used for anti-smoking activities; in particular, this relates to only one small youth campaign in 2002.
Under one quarter had restricted access to tobacco products for people under 18 years, at the same time also eliminating all major impersonal modes of sale.	By law, smoking is prohibited until age 16. The age limit for the purchase of tobacco products differs in the nine provinces, but is not less than 16. However, with a view to cigarette vending machines, the latter may not be seen as a relevant measure to control tobacco consumption. There are no sanctions whatsoever for the consumption, purchase, or sale of tobacco products of/to minors.
Almost no countries reimbursed the cost of treatment of tobacco dependence.	Apart from the rehabilitation centre *Josefhof*, where heavily dependent smokers with a serious smoking-related disease are treated (initially free of cost, now, as with other cures, requesting a small contribution), cessation is neither particularly encouraged nor reimbursed. The few (and often unprofessional) counselling centres offer free advice but treatment has to be paid for by the patient.
Almost no countries published comprehensive national reports on tobacco control.	So far, there is no national report on tobacco control in Austria.
Almost no countries had introduced health warnings and requirements for tar and nicotine at the levels recommended by the Third Action Plan of the ESTC.	Health warnings did not meet the requirements of the EU until September 2003. Tar and nicotine levels, however, are in accordance to EU standards.

Source: Left-hand column: WHO – European Strategy for Tobacco Control[132]*; right-hand column: respective measures implemented in Austria.*

As in almost all countries of the European WHO Region, Austria has established school-based educational programmes, while coordinated, sustainable and gender-based public information and education programmes, strategies or campaigns to promote tobacco control on a population basis are still lacking *(see later)*.[61]

8.2.3 Approaches to tobacco control policy and guiding principles

According to the tobacco control strategies developed by the WHO, the policies adopted by European countries can be grouped "on the basis of their comprehensiveness and multisectorality, their sustainability and progressiveness, the duration and history of implementation, and their outcomes in terms of affecting smoking prevalence and exposure to tobacco smoke".[132] Three basic approaches have been identified:

1) an approach that generally has a weak impact on reducing tobacco use and exposure to environmental tobacco smoke;
2) a transitional approach;
3) an approach that generally has a strong impact on reducing tobacco use and exposure to environmental tobacco smoke.

While, for example, countries such as Norway, Finland and Sweden are already in the third category, the modest achievements in Austria clearly fit in the first category, characterised as follows:

> "Such an approach in general fails to reduce tobacco use. Smoking remains prevalent in all male social classes and continues to grow among young people and women, despite the fact that the majority of adults do not smoke and increasingly favour tobacco control. It is therefore a lack of political will, rather than a lack of public support, that prevents the implementation of a more successful approach."[132]

For countries in such a position, the WHO identifies as a high-priority challenge "to put tobacco control on the political agenda as a key public health issue".[132]

The next stage, the transitional approach, mainly relies on the impact of legislation and information, and attempts to alter society's perception of smoking ('de-glamorising' smoking and increasing people's knowledge). Finally, stage three, is characterised by a set of comprehensive measures and multisectoral strategies.[132]

In conclusion, the ESTC makes the following three points: i) it is the responsibility of governments to make the health of citizens and the protection of human life a priority; ii) it should be acknowledged that non-smoking is the norm and all citizens have the right to smoke-free air

and protection from the damaging effects of environmental tobacco smoke; and iii) it is necessary to decrease daily smoking prevalence, year by year and for every segment of society.[132]

8.2.4 Goals and objectives

As noted above, Austria, Belgium, Germany and Greece are the only European countries of the western hemisphere where no national tobacco action plan exists; nor do these governments have specific goals on tobacco control (except Germany).[61] [c] Yet in all WHO European member states there are interventions to protect non-smokers – although to varying degrees.[40 270 271] It must be noted, however, that the information provided to the WHO is very often restricted to a Yes or No answer, allowing only very cursory interpretation and, at least in the case of Austria, some responses are not correct. It may be assumed, therefore, that the results of these tables are not always reliable. This deficiency in data quality becomes evident, for example, in the responses regarding interventions to support smoking cessation[61] where Austria is supposed to have help lines, cessation clinics, and training of health professionals and medical students. In reality, help lines are information lines, which may not even function; there was only one cessation clinic for heavy nicotine addicts who already suffer from smoking related disease, although there are now a few similar clinics, run by social insurance companies; in some provinces smoking cessation courses have been offered recently; training of health professionals in Vienna consists more or less of a voluntary visit by medical students to the Nicotine Institute where they are shown around; otherwise attendance at educational courses depends on the individual doctor's commitment. Austria's National Awareness Day on 1 January (probably not the best date) and the National Cessation Day on 7 November are largely unknown by the population and pass more or less unnoticed, with virtually no media coverage and accompanied by no campaigns or events[d].

So far, Norway and Ireland are the only countries in western Europe that have banned smoking from restaurants, pubs and bars. In Austria, the only places where smoking is completely banned are the auditoriums of theatres and cinemas, local public transport, and airplanes. In principle, smoking is also not allowed in universities, schools or school sports grounds, but in some universities smoking still takes place in corridors, stairways and refectories, and smoking

[c] Being not a legally binding instrument, Austria has also voted for the so-called Warsaw Declaration and the WHO developed European strategy for tobacco control (ESTC)[132]. On 28 August 2003 Austria signed the Framework Convention on Tobacco Control (FCTC). *(Chapter 5)*

[d] The National Cessation Day in November 2003 was characterised by a hardly advertised campaign of the pharmaceutical company Pfizer with Austrian apothecaries which offered free specimen of nicotine replacement therapy to the first 10 customers on the 6th and 7th November.[272]

in schools is subject to the school's administration as teachers are excluded from the ban and students over 16 years may be allowed to smoke in outdoor premises (some schools are known still to provide smoking rooms for pupils). There are partial restrictions on smoking in health care facilities, education facilities, government facilities, indoor workplaces and offices. However, smoking in workplaces is based on a very vaguely formulated law which is not always adhered to, and restrictions are not uniform. Smoking in hospitals is regulated by the individual hospital directors and is often allowed in lounges, corridors, the hospital cafeteria, and nurses' rooms. Smoking in train stations and airports is not banned but subject to voluntary agreement, as for example the installation of "smokers' corners" at airports *(Section 8.4 and Appendix Q)*.

These examples not only illustrate the deficiencies in Austrian tobacco policy but also the limited validity of such data compilations.

In view of the flexible attitude to smoking restrictions it is not surprising that Austria's discos, bars, restaurants, hospitals, schools and universities are found to be the smokiest and most polluted in a survey of seven EU countries. While in Austrian discos and bars 154.4 microgram nicotine per cubic meter were measured, the comparable figure for Italy was only 26.8 microgram. Average figures for Austrian restaurants were measured to be 29.8 microgram, and Austrian hospitals had 12.2 microgram.[273]

Unlike in some other European countries, as for example France, there is no special unit of the Austrian health insurance fund devoted to smoking. Likewise, there is no separate budget for anti-smoking activities. But there is also no tradition of public health in Austria and reports such as those of the US Surgeon General are only known to very few people.

At present, the Austrian government does not plan to enhance the legal situation (apart from the necessary implementation of the minimum requirements of the European Commission) and no goals or objectives have been set for reduction of smoking prevalence and smoking-related disease, the protection of non-smokers, or the development of an effective tobacco control plan *(Chapter 9; 9.4)*.

The following section will examine those measures that have been adopted in Austria to reduce the demand for and supply of tobacco products and to protect non-smokers.

8.3 Strategic framework: tobacco control measures

8.3.1 Legislation and sanctions

Smoking and other unhealthy behaviours are, of course, to some extent a matter of personal responsibility. Yet this responsibility is not solely a matter for the individual but is shared with governments, who should create a supportive legal environment.[2] However, enactment of legislation does not automatically imply its implementation. In Austria, for example, the regulations stipulated in the tobacco law or the employees' protection law are not always observed by those who should do so; nor are they enforced by official bodies (especially in the case of smoking in public places – to the extent that there are restrictions at all).

There is no doubt that the implementation of the 1995 tobacco law was an important step towards tobacco control in Austria. However, as in the case of the European advertisement and sponsorship directive, the history of this law reflects the dominance of economic interests over health concerns, accompanied by ruthless lobbying. After the first drafts of a comprehensive tobacco law in 1992/1993, which, for example, had included a complete advertising ban and noticeable restrictions on smoking in public places (including restaurants and cafés), the final version was much weaker than had been originally planned *(Chapter 9; 9.3.2)*. Apart from the formal implementation of the recent directives of the European Commission, there are now no more far-reaching proposals.

To better understand the present legal situation and the economic interest of the Austrian government in the tobacco business, a brief history of the tobacco monopoly law is given in Appendix B. The next section will give an overview on tobacco control regulations. Later the relevant laws will be examined in more detail *(see also Appendix M)*.

Laws and regulations for tobacco control measures

Over the past three decades, but in particular since Austria's entry to the European Union in 1995, a growing number of legal measures against tobacco consumption have been adopted, with introduction of restrictions on tobacco advertising and smoking in certain public places.

On 15 February 1979, a decree of the Federal Ministry of Health and Environmental Protection on smoking in hospitals was issued, followed by the requirement for warning labels on cigarette packs (becoming effective in 1982), subsequently strengthened in September 1992. These warnings were not, however, required on point-of-sale promotional material. Three warnings

(in German) had to be used, in rotation: "smoking damages your health", "smoking during pregnancy can damage your child's health", "protect your children from tobacco smoke".[274]

The Employees' Protection Act *(Arbeitnehmerschutzgesetz)* of 1972, as amended by the Federal Act of 20 October 1982, requires employers to ensure that non-smokers are protected from the effects of tobacco smoke in the workplace; when smokers and non-smokers work together in a single room, smoking is forbidden unless non-smokers can be adequately protected by means of additional ventilation.[270 274 275] Apart from the removal of the term 'additional ventilation' this regulation remains in place, despite claims that the law has become "much stricter" following the enactment of a 1995 act which was required to conform to EU law. At the end of 2003, smoking in the workplace (except in the catering business) is regulated by the 1995 Employees' Protection Act, with amendments made in 1999 and 2001[276] *(Appendix M)*.

In 1993, the Minister of Health, Sports and Consumer Protection, Michael Ausserwinkler, proposed a draft tobacco act, which ushered in a total ban on advertising, planned to begin in 1996, along with severe penalties for importers of strong cigarettes. The draft act was subject to harsh criticism and Parliament only passed a much weaker version in 1995.[270 277] *(Chapter 9; 9.3.2)*.

The provisions of the present Tobacco Act, which became effective on 1st July 1995[278], was expected to supplement existing regulations on tobacco consumption. It stipulated a legal restriction on advertising, which was previously subject only to voluntary agreement. Together with other measures (such as, for example, the introduction of smoking 'bans' in schools and with other measures (such as, for example, the introduction of smoking "bans" in schools and the setting of a minimum age[e] for the purchase of cigarettes), it was expected that the rate of uptake of smoking would be reduced.

The act also regulates advertising and strengthens the protection of non-smokers through smoking restrictions in certain premises.[f] By these means, an employee's right to a smoke-free workplace was at last legally anchored, although importantly, employees in the hospitality industry and in enterprises where smoking is allowed by customers were excluded. Finally, some smoke-free environments must be provided in transport facilities. The establishment of smoke-free

[e] Being part of the *Jugendschutzgesetz* (youth protection law), setting a minimum age to purchase cigarettes is a responsibility of the Länder. Regulations differ, but all Länder have a ban on tobacco sales to young people under 16 years of age. Before the introduction of the Tobacco Act, in some Länder it was legal to buy cigarettes from 14 years onwards; smoking, however, was only legal for those aged 16 years and older![279]

[f] In the 1995 tobacco act, smoking is only restricted in premises used for education, negotiations and school sporting activities; rooms accessible to the general public in public authority buildings; universities and vocational training establishments; and establishments used for performances or exhibitions.

environments (or rather, non-smoking zones) in restaurants and cafés was suggested but not regulated.

Another feature of the 1995 tobacco law was that smokers themselves were to be 'protected' by regulations on the quality of tobacco products, limits on some harmful ingredients (such as additives, pesticides, residues, etc.), as well as provisions for labelling.[g] However, until now, the Health Ministry has issued no order regarding cigarette additives. Thus, additives are not regulated by any law, making law suits very difficult[280] *(Chapter 9; 9.4)*.

The Tobacco Act of 1995 was amended in 2001 to take account of the introduction of the Euro[30] *(see above)* and in 2003 with regard to the formal implementation of the EC Directive 2001/37/EC into Austrian law.[278] The main amendments affect labelling in respect of tar-, nicotine- and carbon monoxide content, warning labels and more detailed justification of additives. The amendments do not make provisions for more restrictive bans on smoking in public places or for any kind of enforcement. They also do not offer a means to increase existing fines or create new fines for violations of the act.

Notwithstanding these changes, following the 1995 tobacco law restricting advertisements, the World Tobacco File 1998 reported that "in comparison with other parts of the European Union, restrictions and regulations concerning smoking and tobacco advertising in Austria are relatively relaxed".[72] This conclusion still holds today.

A more detailed description of laws on advertising and sponsorship and laws on product control and consumer information can be found in Appendix M.

Summarising laws on smoking restrictions in public places, the following regulations are in force: Smoking is restricted by the 1995 tobacco law in public buildings, schools and universities, cinemas and theatres. The employees' protection law regulates smoking in the workplace. Voluntary restrictions exist on local public transport, underground stations, trains and airlines, with the provision of a "sufficient number of smoke-free environments in fixed location facilities" being suggested. No restrictions are in force in restaurants or bars. Taken together, this

means that there is no law on clean indoor air; the only places where smoking is completely banned by law are the auditoriums of cinemas and theatres.

A more detailed overview of smoking restrictions in schools, workplaces, and hospitals is given in Appendix M.

Sanctions

Unlike in Canada, where employers who violate smoking regulations are subject to fines ranging from C$500 (€310) for a first offence, to C$10,000 (€6,200) for each offence after the third[165], or in Italy, where individuals caught smoking in public places are fined €250, or even €500 if children or pregnant women are present, and restaurant owners who do not install proper ventilation in areas designated for smoking risk a fine of €2,000 and temporary closure *(Chapter 4)*, the situation in Austria is much more relaxed. Except for a fine of less than €7,000 for violating the advertising law (or up to €14,000 in the case of repeat offence) no legal sanctions exist. Employers who do not make provisions to protect non-smokers, pupils under 16 years of age caught smoking, or individuals smoking in non-smoking zones may be 'admonished'. As usual, 'voluntary agreement' and 'mutual understanding and tolerance' are the basic approaches to these issues in Austria. Instead of sanctions, the handling of infringements of health regulations by employers is seen to be more promising by the provision of "information and advice to employers and employees by officials of the Regional Labour Inspectorate *(Arbeitsinspektion)*, as well as co-operation with workers' councils and internal experts in prevention".[281] According to the Chambers of Labour *(Arbeiterkammer)*, though, repeated violations of non-smoking regulations have been reported to have led to dismissal in some cases.[275]

Smoking in public transport and underground stations is regulated by transportation rather than tobacco law. Although smoking is prohibited in underground stations, this ban is only occasionally enforced by staff. The fine is, however, only €40 (compared to €60 for fare dodgers)[282] *(Appendix Q)*. An official from the Austrian Federal Railways stated that he would wish to have

[g] Subsequently, and in compliance with EU regulations, the content of condensates in the smoke of cigarettes (tar yields) was limited to 15mg per cigarette by 31 December 1995 and 12mg per cigarette by 31 December 1997. Nicotine and tar yields had to be displayed on the small side of every cigarette pack. The wording of warning notices on cigarette packs was also tightened, in order to comply with EU regulations. Therefore, the front side of each cigarette pack had to display the warning 'smoking endangers your health'. In addition, on the flipside of the pack, one of four warnings had to be used alternatively (with the same frequency of occurrence), printed clearly and covering at least 4% of the pack: "smoking causes cancer", "smoking causes cardiovascular diseases", "smoking endangers your child's health already during pregnancy", and "stopping smoking reduces the risk of serious diseases".

stronger powers for sanctions in railway stations but would meet strong opposition from others.[283]

EU law requires member states to impose "proportional, effective and deterrent sanctions" where an offence takes place.[284] As noted above, the only sanction currently existing in Austrian tobacco law is a relatively low fine for violating advertising restrictions. It must be doubted whether this is a "proportional, effective and deterrent" sanction against the tobacco industry, the media, or the advertising agencies. At present, no further sanctions are planned. In addition, inquiries to various departments at federal and provincial level identified no-one responsible for enforcing this law.[h]

In summary, the efforts of all concerned to avoid any kind of 'confrontation', and ignorance of who is responsible to ensure compliance with the law (even if, in theory, it should be the Ministry of Health), mean that any sanctions are essentially symbolic. Yet, according to the State Secretary and his staff, no other measures are under discussion.

8.3.2 Price and taxation

Cigarette prices

At the end of 2003, most packets of 20 cigarettes[i] were sold at a price between €3.00 and €3.30.[75] According to *Austria Tabak*, the average price of most popular cigarette packets was €3.30 in 2003.[70] The highest sales (in this order) were of Marlboro, Memphis, Milde Sorte (now: Meine Sorte), Gauloises, Hobby, HB, Dames, Philip Morris, Camel, and Casablanca *(Appendix C)*.

Taxes and Duties

For decades, *Austria Tabak* has controlled the government's tobacco taxation agenda and, whenever the question of raising tobacco taxes arose, it was common to ensure its representatives were party to preliminary talks. In various discussions this was explained by the fact that *Austria Tabak* was a state-owned enterprise and its chief executives were closely linked with government representatives at the highest level *(Chapter 9)*.

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h Finally it was found that it is handled on the district level *(sic)*, where complaints have to be specified with the exact description and location of this violation when presented at the respective district office – which is not very likely to be done by anyone. From the individuals contacted, nobody remembered if this was ever the case; however, as there are no data available as to number of law suits or amount of fines one would have to contact each of these district offices in the whole country separately to get more information.[285]

i Unlike in some other countries, packets with less than 20 cigarettes are not on the Austrian market.

Since Austria became a member of the EU, it has been possible to observe a sharp rise in taxes. Before EU entry, taxes had remained constant for a very long time, with the highest tax rate (excluding VAT[j]) being for cigarettes (55% of the retail price), followed by fine-cut tobacco (47%), pipe tobacco etc. (34%) and cigars (only 13%) – which is interesting from a social point of view, as cigars are usually smoked by wealthy people who could afford to pay more taxes.

Austria's EU entry also led to a reorganisation of tobacco taxation, i.e. the change from an *ad valorem* tax system to a composite tax rate. In August 2002, the total taxes for cigarettes were 58.67% (42.00% *ad valorem*; 16.67% V.A.T.), that is €21.38 per 1000 pieces. Based on the most popular price class, the overall tax burden of a cigarette pack with the retail price of €3.00 was €2.19, that is 72.9% *(Appendix N)*.[70]

According to the World Tobacco File 1998, the increase in cigarette prices in Austria between 1994 and 1997 amounted to 30%; in subsequent years no data were made available by *Austria Tabak*. The price increases in 1994 and 1995, following sharp rises in taxes, have been linked to a growth in cross-border and contraband sales and hoarding by consumers, but also to a slight decrease in the number of cigarette smokers,[72] consistent with evidence on the price elasticity of tobacco *(Appendix F)*.

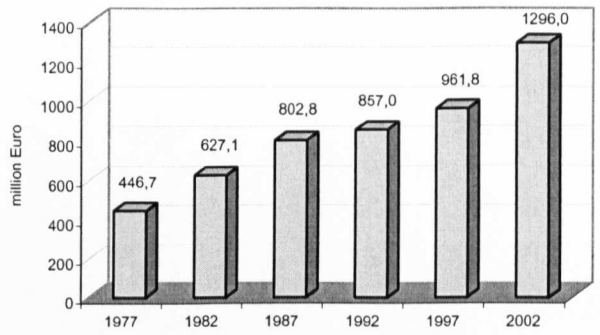
The scale of tax revenues from the sale of tobacco products is enormous. Only considering consumption of cigarettes, which constitute the biggest share by far within all tobacco products, the revenues from taxes for all EU member states amounted to nearly €55bn (excluding VAT) in 2001. The highest sums were raised in the United Kingdom (€11.8bn), Germany (€11.6bn) and France (€8.2bn).[39]

In 2002 in Austria, the tax income from tobacco products amounted to €1.3 billion, corresponding to an increase in tax revenues of 35% since 1997, although this excludes 20% VAT, amounting to an additional €456.5 million, so that total tax revenues in 2002 amounted to €1.8 billion *(Figure 8.2)*.[70] This is consistent with evidence that increasing tax rates both decreases consumption and increases total tax take.

It is, however, important to note that data on tax revenues differ slightly according to whether they are supplied by the Ministry of Finance[286] or by *Austria Tabak (Figure 8.1 & Figure 8.2)*.

j VAT (Value Added Tax) in Austria: 1973-1975: 16%; 1976-1983: 18%; since 1984: 20%.

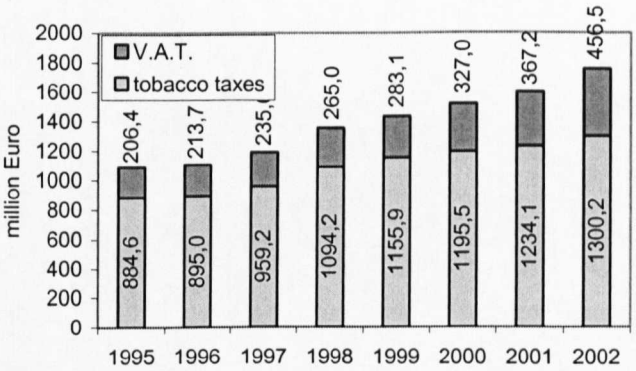
Figure 8.1 Annual tax incomes from the sale of tobacco products in Austria from 1977 to 2002 (in million Euro) (excluding V.A.T.) *



* Not adjusted for inflation and average spending power.

Source: Austrian Federal Ministry of Finance, balance of accounts (Bundesrechnungsabschlüsse).

Figure 8.2 Tax revenues from tobacco taxes and V.A.T. from the sale of tobacco products in Austria from 1995 to 2002 (in million Euro) *



* Not adjusted for inflation and average spending power.

Source: Austria Tabak Gallaher.[70]

Use of tax revenues

In Austria, tobacco taxes are not earmarked. There was only one attempt, made by the former health minister Michael Ausserwinkler in 1993/1994, to allocate tobacco taxes to anti-smoking activities – the, informally, so-called *"Rauchermilliarde"*, with the term reflecting the approximately ATS 1 billion to be raised by the proposed extra charge of 50 Groschen (€0.04) on every pack of cigarettes. These funds should have been transferred to the Fund for a Healthy Austria to finance treatment and support of anti-smoking campaigns. However, due to strong opposition (economists argued that this measure would promote inflation) this initiative could not be realised *(Chapter 9; 9.3.2)*.[277] Although a small proportion of tobacco taxes have been

used to fund general health promotion activities for many years, these are not specifically related to particular anti-smoking activities.

In 2002, a regulation enacted within the framework of the general social insurance law (*Allgemeines Sozialversicherungsgesetz)*[287] decreed that the Federation of Austrian Social Insurance Institutions' (in short: Social Insurance Funds) equalisation fund should receive additional income following the rise in tobacco taxes in August 2002. This was to be a flat rate of about €82 million for every year.[k] However, the advance payments made to the equalisation fund exceeded the tax gains and an amendment to the law *(Budgetbegleitgesetz)* seemed necessary. At the time of writing (April 2004), however, there has been no agreement between the Finance Minister and the Health Minister on this issue.[l] [14] [286]

Thus, these funds have never been used specifically for any kind of anti-smoking initiatives[m] although they have been used to support the Social Insurance Funds which have been (and still are) badly in debt. Despite evidence of the very high health care expenditure attributable to smoking-related diseases (estimated to be 15-20% of total expenditure, i.e. €1.5 to €2bn[14]), there is no special unit within the Federation of Austrian Social Insurance Institutions responsible for smoking prevention and no particular anti-smoking activities have been established so far, nor are there any plans for them. The only specific expenditure on combating smoking is funding for 3-week courses of treatment for heavy nicotine addicts with severe smoking-attributable disease. These costs are, however, met by regional health insurance funds[n] *(Section 8.3.5)*. A contribution of approximately €50,000 from the Social Insurance Funds to the Fund for a Healthy Austria for general health promotion measures is obviously thought to cover all

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[k] It is not yet clear if this amount will be financed by the tobacco tax or the sales tax.

[l] In 2002, the equalisation fund received advance payments for the months September, October and November, estimated on the expected tax gains, totalling about €82 million. In December 2002, the Finance Ministry realised that, in contrast to these expectations, total tax revenues have not increased as expected, and no more money was transferred for December. Thus having transferred too much money to the Social Insurance Funds, which could not be returned to the Finance Ministry, a change of this flat rate seemed necessary.[286] While Reinhart Waneck, the Austrian State Secretary of Health (Austrian Freedom Party, FPÖ), would be in favour of a fixed amount, the Austrian People's Party (ÖVP) and its Finance Minister Karl-Heinz Grasser (formerly FPÖ, now 'independent' but close to ÖVP) are opposed to it, preferring, if at all, a yearly modified amount.

[m] Although the State Secretary of Health, Reinhart Waneck, claims that the spokesman of the executive board of the Social Insurance Funds, Josef Kandlhofer, assured that 'every penny' received from the tobacco taxes would be used for preventive measures in tobacco control[288], whereas, according to a newspaper article, Kandlhofer himself declared that (only) part of this funding will be used for "preventive" measures for smokers[289] (i.e. support of treatment for severely ill smokers). Instead, according to information received from Josef Kandlhofer, this additional funding will go (and has gone) into an equalisation fund where an accurate mode of account is not possible. Therefore, no information could be given as to how much money was actually spent for measures on smoking prevention as this money has not been earmarked and the present accounting mode does not allow money to be traced.[14]

[n] Although the regional health insurance funds also receive indirectly funding by this equalisation fund, this money is not earmarked for any purposes.

responsibilities by Austria's health insurance system. However, the activities of the Fund for a Healthy Austria targeted at smoking are considered very weak *(see later)*.

In September 2003, on the occasion of the delayed implementation of the EC directive 2001/37/EC, Austria's State Secretary of Health, Reinhart Waneck, voiced his view that a planned reform of voluntary screening programmes should be financed by tobacco taxes.[o] The question of further increases in tobacco taxes was rejected by Waneck, arguing that this expansion of screening programmes did not require an increase in tobacco taxes.[159] However, an enquiry in July 2004 at the Social Insurance Funds about the state of affairs revealed that, due to lack of money, the programme, which is planned to start on 1 January 2005, should comprise even fewer examinations than it did previously but will instead offer more information for smokers about harms of smoking and advice on smoking cessation. Doctors would be given a manual on how to proceed.[p] [291]

The mainly government-funded Fund for a Health Austria *(Fonds Gesundes Österreich, FGÖ)* is the national organisation for health promotion activities. It receives funds from the government as a fixed amount of import duties on tobacco products purchased outside the EU, amounting to €7.25 million per year. However, the anti-smoking activities of the FGÖ are confined to the minimum expectations of EU-wide (and rather ineffective) efforts to tackle smoking among young people *(see next section)*. According to personal communication with one of the organisers of a European road show, the Austrian response, particularly in Vienna, was very poor and badly organised.[292]

[o] These screening tests, used only by approximately 12-13% of the population, should include cancer-, skin- and lung examinations for smokers. A critical article in the Austrian newspaper *Kurier* expatiates on the fact that, although cigarette prices and taxes have been increased continuously over recent years, justified by the need of financing the health care system, these funds in fact have seeped away somewhere.[290]

[p] No answer could be given regarding the apparent lack of offers for smoking cessation *(see later)*. As usual, it was only referred to the *Josefhof* in Graz as a kind of model cessation project *(see later)*, where severely ill smokers are treated in a three weeks cessation programme – one could say, a kind of 'last chance' for smokers.

8.3.3 Advertising and sponsorship

Advertising

Austria will have to implement the EU directive on advertising restrictions. However, despite occasional lip service paid by politicians to the importance of banning advertising[q], there have been no signs whatsoever that Austria has any intention to either hurry or go beyond the minimum requirements demanded by the European Commission.[r]

In the international literature, Austria's attitude towards tobacco advertising has therefore rightly been described as "very relaxed", with a "mild climate" based on "broad consensus". Almost every measure is seen as 'too extreme' or 'militant' *(Chapter 9)*. In the Austrian newspaper *der Standard*, the recent advertising directive of the European Commission is described as a "missionary fight" by the EU Health Commissioner David Byrne against cigarette consumption. In some member states, so the commentary reports, advertising restrictions were followed more strictly, in others regulations were rather of the "mild sort" [s].[293] Although the situation is similar to that in Germany, where strong pressure on decision makers has been reported [t], it probably does not need great pressure from interest groups on the government in Austria for it to reach a 'broad consensus'.

As noted, the 1995 Tobacco Act stipulates that tobacco advertising should not attract young people and models should therefore not be (or appear to be) younger than 30 years of age. In addition, no cartoons should be used. Although nobody ever complained about it, cigarette advertising often portrays seemingly young people (even if they are reported to be above 30) and the Casablanca cartoon[u] in underground stations *(see Picture 2 in Appendix Q)* is apparently one of the exceptions.

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[q] One example was a letter from the then Health Minister, Herbert Haupt, and the State Secretary of Health, Reinhart Waneck, to the then Director General of the WHO, Gro Harlem Brundtland, dated at the beginning of 2003. This letter emerged in the course of the preparations for the final negotiations for the Framework Convention on Tobacco Control, which includes Article 13 referring to a total advertising ban. Haupt and Waneck affirm that, from the viewpoint of health politics, a total advertising ban would be 'very desirable'. Tobacco advertisement would contribute to tobacco consumption and therewith to tobacco-related diseases. Experts would therefore see a total advertising ban as one of the most effective means to counteract the increase of smoking.[279]

[r] In 1993, the Health Ministry issued a draft tobacco law which ushered in a total ban on advertising to begin in 1996. The draft law was subject of harsh criticism and was among the main reasons behind the removal of the then Health Minister Michael Ausserwinkler *(Chapter 9)*. Only in 1995, when Austria's EU entry made action necessary, did Parliament pass much weaker legislation, which included only partial advertising restrictions.

[s] Hinting at the Austrian bestseller brand 'Milde Sorte'.

[t] According to David Byrne, these initiatives were meant to be a "coffin nail" for the tobacco industry. The German newspaper editors, however, sensed that it would also be a coffin nail for them and, with a view to the present crisis in the advertising business, made pressure on the German government.[293]

[u] Casablanca is the 10th popular cigarette brand in Austria *(see Appendix C)*.

Hidden advertising (with pictures of smokers) in the media is not uncommon, in particular in articles dealing with the subject of non-smoking *(Chapter 9; 9.3.8)*.[39 265]

The 1990 youth campaign provides insight into images of smokers and non-smokers. According to the advertising agency involved, the image to be projected should be a strong, self-confident, independent, freedom-loving, humourous, sporting, sociable, and modern youth. In fact, this image is identical with that advertised for smokers. However, a survey among youth reported that the 'undesirable' characteristics ascribed to non-smokers would be good, well-behaved, conform, unsociable, puritanical and health conscious.[294]

Several Austrian advertising agencies have been commissioned by *Austria Tabak* to undertake cigarette advertising. For example, BBDO has been commissioned to promote *Milde Sorte*; FCB Kobza, *Memphis Classic*; Saatchi & Saatchi, *Memphis Blue*, etc. Only one agency, however, volunteered limited information about target groups, advertising objectives, compliance with tobacco law, client briefs and information on brand characteristics. Two explicitly declined any kind of information and hung up immediately. The information presented below is based on discussions with a key informant who did not wish to be named.

According to the industry's briefing to the agency, the general aim of cigarette advertising is to confirm regular smokers in their choice of brand (brand loyalty), to promote preference for domestic (Austria Tabak) brands, in particular from the 'light' range, to promote a positive image, and, of course, also to win new customers. In previous years, when *Austria Tabak* was still state-owned, the foreign brands *Marlboro, Gauloises,* etc., have represented the foe. Today, this is different and in the future, a decline in home brands and an increase in foreign brands are predicted.

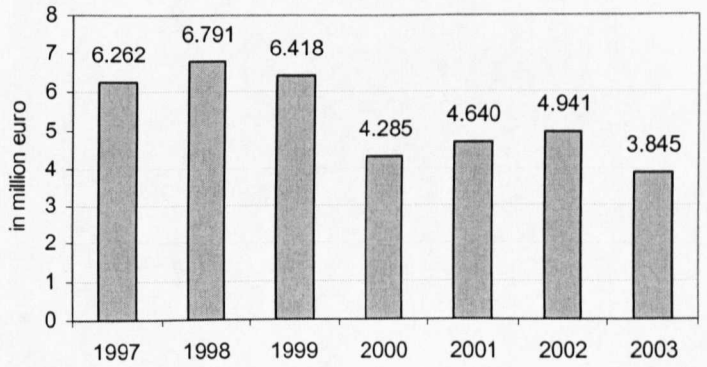
The definition of target groups is based on market research. For example, the original target group for *Memphis Classic* were men aged 35 years and over, from rural rather than urban areas. However, this target group has been expanded. On the other hand, the target group for *Milde Sorte*, Austria's most popular 'light' cigarette, still are young women of the 'housewife-type', aged 25 years and over.

With regard to the age limits for models it was assured that, before shooting, every model had to sign a statement that he or she was not under 30 years old. It was stated that, if the model lied, at least, the advertising agency has covered itself with this signature. Of course, if the shooting takes place outside the Schengen zone, passports are needed – and checked.

Advertising strategies are developed through team work, drawing on past experience. Although the agency receives a basic briefing by the tobacco company (more detailed information was not disclosed), the concepts and designs are said to come from the agency.

As noted above, tobacco advertising is permitted in cinema (G-rated films, but not in films targeted at children and youth), outdoor advertising (billboards etc.), and print media (local weekly magazines, magazines, professional journals). The breakdown of expenses incurred by the German tobacco industry shows that the biggest share (37.4%) is spent for outdoor advertising.[295] No data were provided by the Austrian tobacco company about its annual advertising budget. However, an Austrian market research company was able to give information on expenditure on cigarette advertising since 1997 *(Figure 8.3)*. From the beginning of privatisation of the Austrian tobacco company in 1999/2000, a striking decrease in cigarette advertising can be observed. Since then, however, expenses have risen, amounting to almost €5 million in 2002, before decreasing to less than €4 million in 2003.

Figure 8.3 Expenditure on cigarette advertising in Austria, 1997–2003 *



* Not adjusted for inflation.

Source: *Media Focus Research.*[296]

It has been commonly said by politicians[297] and government officials[298] that *Austria Tabak* has been the biggest advertising client. However, analysis of advertising expenditure (i.e. "classic" advertising, including print media, bill boards, and cinema advertising but excluding hidden advertising in the form of sponsoring) shows that tobacco advertising is by far not as predominant as, for example, advertising for telecom companies, cars, washing powders, or supermarkets.[296]

Sponsorship

Although no data were provided by *Austria Tabak* about its promotional budget, the company is known to spend heavily on cigarette advertising and, probably less transparently, for sports sponsorship. With its former General Director Beppo Mauhart being at the same time head of the Austrian Football Federation, the involvement of *Austria Tabak* in sports is self-evident *(Chapter 9; 9.3.1)*.

In Austria, it is widely known that sports clubs, in particular football clubs, are sponsored by *Austria Tabak*. The company also sponsors the Austrian ski team (which uses the logo of Memphis)[299] and, until it was banned, it also sponsored Formula One. At least until privatisation, *Austria Tabak* has been known to sponsor arts, horse races[v], and many other events. A 1987 article reports that "Austria Tabak, despite restrictions on advertising, builds its image through sponsorship of arts and sport". It adds that the company is "the largest non public sponsor in Austria".[301] It was not possible to get information on the subject of 'donations' to political parties.

Reinhart Waneck, the then Austrian State Secretary of Health, claims that he has been trying to persuade the pharmaceutical industry and other industries to take over sponsorship at football pitches, so one would "not be dependent on Memphis". So far, however, these companies have not shown much interest. Waneck's account shows that the relationship between the government and *Austria Tabak* is characterised by mutual understanding of the respective interests and assumed goodwill.

> *"Interestingly, the tobacco industry would have no problems at all with that [being stopped from advertising at football pitches]. They have told me that they do not need that, because people do smoke anyway. And the more it is prohibited, the more business they make. That means, here you really have to think about new ways, together with the tobacco industry, but it would be far better to win other companies. It is also an issue for the Finance Minister with regard to tax policy. He would need to grant that anti-tobacco advertising can be written off against taxes in any event."*[288]

[v] An Austrian 1988 sports newspaper reads: "Austria Tabak – long-known for its sponsorship of various football clubs – has now donated a prize for horse-racing. The 'Maverick' Grand-Prix was run for the first time on Vienna's Freudenau course on 1st May".[300]

8.3.4 Information, campaigning and training of health professionals

At present, the government's few efforts to reduce smoking have been confined to pointing to alarming rates of smoking among young people, particularly among young women, and to small and mostly ineffective youth campaigns which are supposed to prevent children and adolescents from taking up smoking. The reduction of the toll of premature death from smoking-related disease, the high health care costs for smoking-related disease, and the protection of non-smokers are essentially missing from Austrian health policy.

Annual anti-smoking days, such as the Non-Smoking Day on 31 May, the National Cessation Day on 7 November, and the National Awareness Day on 1 January, pass more or less unnoticed – at least in Vienna. Apart from some media coverage and expressions of good-will by national health politicians, no public events or campaigns are taking place. However, unlike the situation in Vienna, activities in Vorarlberg and Tyrol were reported.[302 303]

The only comprehensive anti-smoking campaigns that targeted the whole population took place at the beginning of the 1980s and, to a limited extent, in the mid 1990s. Population-wide dissemination of information and implementation of educational measures about the dangers of smoking and the recognised difficulty in quitting are lacking, and therapeutic support for those willing to quit are still limited and often unprofessional.

In particular, there is not much information about the dangers of second-hand smoke, and no appeal to those who smoke to consider non-smokers. In addition, although smoking is restricted in some public places by the 1995 tobacco law, these regulations are not always adhered to. In contrast with countries like Norway, Finland, Sweden, the United States, Canada, Australia, or New Zealand (to take just the best known examples), smoking in Austria is mostly still seen as a matter of 'personal freedom' and 'personal choice' and little consideration is given to those who feel harassed by this activity.

Although efforts directed at adolescents are doubtless very important as adolescence is "a critical life stage when life-style choices are established, including health-related behaviours with impacts throughout life"[2], it has been shown repeatedly that youth campaigns must be part of a population-wide and comprehensive anti-smoking programme to yield positive results *(Chapter 4)*.

Apart from these limited activities, information on smoking-related issues is provided by a website served by the *Initiative Ärzte gegen Raucherschäden* (Austrian Council on Smoking

and Health – or: Initiative of Physicians against Harms of Smoking), formed by the Austrian Society for Lung Diseases and TB, the Institute of Environmental Hygiene of the Medical University of Vienna, the Institute of Social Medicine of the Medical University of Vienna, the Austrian Cancer League, and the Austrian Medical Council. Its activities, however, seem confined to the provision of this website.[304]

Anti-smoking campaigns

In 1980, the first anti-smoking campaign was launched in Austria, followed in 1985 by a second campaign using the same name. Both campaigns were very short but profited from the popular slogan *Ohne Rauch geht's auch* ("Same Without Smoke")[w] which is still remembered today, even among younger people. In 1990, a small youth campaign with the vacuous slogan "Smoke off" took place. In 1994, the second (or third, if one counted the small 1985 repetition campaign) was launched, repeated in 1995 (although with a much smaller budget than the 1994 campaign). While these two major campaigns with their small-scale repetition were directed at the whole population, the few subsequent campaigns have been targeted exclusively at children and teenagers. All campaigns are described in more detail in Appendix O.

The population campaigns were initiated solely by the Austrian Ministry of Health and can be ascribed to the two health ministers Herbert Salcher and Michael Ausserwinkler, who were both very engaged in anti-smoking politics despite facing strong opposition and even personal attacks *(Chapter 9)*. While the predominant features of the 1980 campaign (Herbert Salcher) were its effective slogan, intense media coverage, and targeting of the entire population, the main goal of the 1994 campaign (Michael Ausserwinkler), which consisted essentially of an information brochure and stickers, was to promote the tobacco law and to address political opinion leaders as an important target group *(Chapter 9)*.[x] The cost of the 1980 campaign was particularly low at only about ATS 7 million (equivalent to €500,000), largely due to media support with free cost services[y]. Considering that this campaign lasted a very short time, it may be considered very successful. According to an accompanying survey, about 200,000 people

[w] The only one who complained and wanted to sue the Ministry (which eventually did not happen, though) was the Austrian manufacturer of fruit juices with the same name 'Rauch' as, due to its popularity, the slogan was jokingly used in variations.[305]

[x] While today the health ministry claims that this campaign actually resulted in the successful implementation of the Austrian tobacco law in 1995, it may safely be assumed that the greater force behind its implementation was Austria's EU entry. Although much weaker than the original draft *(Section 8.3.1)*, the new law at least included smoking restrictions in public buildings and constraints on advertising.

stopped smoking at that time. Although this effect was very short lasting, it shows the potential for intense and prolonged tobacco control programmes. The cost of the 1994 campaign was higher, about ATS 20 million (€1.5 million) – a considerable proportion of the health ministry's budget, but still only about 5% of the advertising (and sponsorship) expenditure of Austria's tobacco company for one single campaign at that time (including hidden advertising).[277]

Over recent years, Austria's anti-smoking policy has thus been focused on children or rather teenagers, with the intention of preventing them from taking up smoking. Apart from the brief 1990 youth campaign "Smoke off", the exclusive focus on children and youth started in 1996/1997 with the Ministry's commission of an association named "Young and Non-Smokers" with a health education campaign aiming to initiate a rethinking of the symbolic power and meaning of cigarette consumption. This campaign passed more or less unnoticed. In 1998, the equally unnoticed, but industry-funded government campaign "smoke sucks" followed. In 1999, the Austrian Cancer Society ("Don't start, be smart") and in 2002, the Fund for a Healthy Austria (*Ich (b)rauch(s) nicht* = "I don't need it, I don't smoke") have also initiated anti-smoking youth campaigns. Recent initiatives include a project entitled *Rauchfreie Schule* ("Smoke-free Schools") and participation in the EU-wide youth campaign "Feel Free to Say No" *(Appendix O)*. In the course of these campaigns, information has been made available on the dangers of tobacco use. Some of the most recent anti-smoking campaigns have included efforts to work with teachers and students to create smoke-free classes or schools. In May 2004, a small and little advertised campaign as part of the international "Quit and Win" programme was launched, also supported by the health ministry.

Other funds or organisations or even individuals acting at local level (especially in the federal provinces Vorarlberg, Tyrol, and Upper Austria) have also launched initiatives for children and teenagers recently, or are giving educational talks at schools.

As was already mentioned, a more detailed description of the various campaigns which have been mounted in Austria since 1980 can be found in Appendix O. Chapter 9 will also explore in more detail the background of the 1980 and 1994 campaign *(Section 9.3.2)*.

According to the Health Ministry, the reason for this exclusively youth-targeted approach has been the results of the HBSC studies which report a significant increase in smoking among

[y] This fact was obviously not well received by *Austria Tabak* who complained about the "inequality of weapons". The campaign, so the company publication, "not only received time free of charge in the electronic media, which are forbidden to us, but which also involved speakers, sometimes very prominent speakers, who were prepared to make spontaneous comments".[71]

children and teenagers over the last 15 years and the continuous decrease in the age at which smoking commences. In a two-minute conversation before suddenly rushing off, a government official, who is responsible for health promotion including anti-smoking campaigns, said at the Helsinki Conference that campaigns targeted at the general population would not be effective *(sic)*, and it would be much better to focus on youth campaigns. The fact that youth smoking rates have not decreased but rather increased over recent years (and still are increasing), despite various youth campaigns, was brushed off with the remark that "one has to target one's efforts", because of limited resources.[306]

In the light of continuously increasing smoking rates among Austrian teenagers, which are now among the highest in any EU country, the effectiveness of various youth campaigns may be summarised as being very limited at best, counter-productive or profoundly ineffective at worst. Furthermore, it would seem that this is not only the fault of the rather meaningless slogans selected in English language, which cannot even be translated into German in a way that makes sense (e.g. "smoke off", or the rather unappealing "smoke sucks") but also due to the often patronising manner of the campaigns.

Nevertheless, Austria's health politicians seem to be rather pleased with themselves and the results of their efforts. Reinhart Waneck, State Secretary of Health and president of the Fund for a Healthy Austria, stated in the foreword of its 2002 report that the slogan "I don't need it – I don't smoke' "encouraged children and youth not to start smoking"[307]. Whatever he meant by "encouraged", it is perhaps the most one can say about this very short campaign (lasting only a couple of weeks) without it becoming an overstatement.

Maria Rauch-Kallat, Austria's present Health Minister, in a statement made to coincide with World No Tobacco Day on 31 May 2003 (while again referring to the alarming HBSC data) called for increased prevention, particularly for young women. The Social Insurance Funds also took this opportunity to "affirm to intensify its activities"; so far, however, without visible results. In her statement, the Health Minister proposed a "broad health promotion movement" to animate Austrians – particularly certain target groups – for more health conscious behaviour, including reducing smoking. Once more, 14-15 year olds were seen as the main target group.[289] As of June 2004, however, nothing has been heard about it, and no actions have taken place.[z]

[z] Another advertised campaign that nobody ever heard of again was a 'planned' anti-smoking initiative to target pregnant women ('even' funded by the Austrian tobacco company!), announced after the TV programme on anti-smoking measures on 5 November 2003.[303]

Given the evidence from elsewhere of tobacco industry support for youth smoking campaigns, it does seem to be the case that, for most of the campaigns, the funding seems to be 'clean'. Inquiries to the Austrian Cancer Society about its campaign "don't start, be smart" revealed that much care was taken to assure that no tobacco industry money was contributed. Despite persistent rumours of *Austria Tabak's* involvement in the government campaigns, only one was reported to have been funded by the Austrian tobacco company: the youth campaign with its unappealing "smoke sucks" slogan and its equally unappealing pictures of youth and its symbols (as, for instance, a raised middle finger in the form of a cigarette).[308] As to the youth campaign with the equally mysterious slogan "Smoke off", where sponsorship had been necessary because of the very modest health ministry's budget[294], no information could be obtained about the identity of sponsors.

In summary, all of the Austrian campaigns can be described as rather small-scale, low-budget and short-lasting. The very first campaign in 1980 was certainly the one whose effects lasted longest and possibly, despite an increase in smoking rates between 1981 and 1984 after a brief decline following the campaign, also the most successful. Both the 1980 and the 1994 campaign, however, could have been much more successful if they had lasted longer and the two motivated ministers had faced less opposition. Even in relation to the small overall budget for health promotion activities, the budget for anti-smoking initiatives has been very small so far (with the exception of the 1994 campaign) and efforts particularly over the last 15 years have been decidedly unimpressive. In particular, they can be contrasted with the expenditure on advertising campaigns by *Austria Tabak*, which in the mid 1990s amounted to ATS 300 to 500 million (ca. €21 to 35 million) for each campaign[277 279] (apparently including indirect advertising and sponsorship), Austria's anti-smoking campaigns are declining to the point of non-existence. According to the State Secretary of Health, Reinhart Waneck, the main constraint on the health ministry from launching a sustainable and effective anti-smoking campaign is the limited budget. Needless to say that there are currently no discussions whatsoever regarding a comprehensive package of tobacco control measures or at least a well-designed population-wide campaign.

Training of health professionals

In Austria, health professionals are not specifically trained to give advice and support to those willing to quit. If physicians or pharmacists are interested they may attend some continuing educational courses.[272 309 310] Medical students in Vienna are invited to pay a visit to the Nicotine Institute (which does not, however, offer cessation courses) to be shown around for one or

two hours.[191] The new health screening programme, proudly announced by the State Secretary to be partly financed with tobacco taxes, should provide information and advice for smokers to quit. "Training" of doctors consists of handing them a manual on how to proceed. As the following section on smoking cessation programmes shows, it remains unclear yet where smokers who should wish to quit smoking and who are not already ill enough for the *Josefhof (see below)* will be sent to for help.

8.3.5 Smoking cessation, therapeutic measures

On the occasion of the 2003 World Tobacco Conference in Helsinki, the WHO "urged governments to include smoking cessation and treatment services as part of comprehensive tobacco control programmes, stressing that therapies for tobacco dependence can contribute substantially and immediately to health gains".[311] The guidelines, developed by experts, should provide countries that wish to implement the FCTC with an evidence-base. However, as Vera da Costa e Silva, WHO's director for tobacco control noted, despite overwhelming evidence of the health benefits of quitting smoking, and the effectiveness of treating tobacco dependence, "the public health sector in many countries is not investing in smoking-cessation services, and in most countries only limited steps have been taken to provide treatment, train health-care providers, and release financial resources. Smoking cessation is very often not seen as a public health priority, or included in governments' tobacco control strategies," she said. Because of tobacco's addictiveness, many smokers will need support to quit."[311]

Smokers who want to give up smoking require various forms of support. However, as advised by the WHO and other experts, a multisectoral approach should be the aim *(Chapter 4; Appendix F)*. In addition, a "supportive environment is needed to encourage smokers to quit: higher tobacco taxes, advertising bans and smoke-free public places contribute to raising awareness and decreasing access to tobacco products".[298]

Although Austria proudly points to the fact that it was "one of the first countries to sign the FCTC"[298] there are no signs whatsoever of it implementing any of its provisions. At present, smoking cessation is definitely one of the least important elements in Austria's tobacco policy and accordingly plays a little part in shaping the population's attitude towards smoking.

There is very little support for smokers who are considering the idea of giving up smoking, and even less information about where help can be found. Neither is there any kind of advertise-

ment of even the few cessation programmes in the media.[aa] Not surprisingly, giving up smoking is widely seen as very difficult task and, above all, a 'personal' or 'individual' problem. In general, therefore, smokers who have already reached a stage where they are really willing to give up smoking have to search actively by themselves for support. There is no help-line now although one did exist previously for a short period, operating for three hours a day, but it was not very successful and no-one would accept responsibility to pay for it. Potential quitters inquiring at the Vienna Nicotine Institute have their details noted and, once there is a sufficient number (usually once or twice a year), a one-hour talk will be given in a rented location to all who are still interested. The official approach is essentially that "one has to earn the treatment", and difficulty in accessing these services is seen as something positive, showing the real commitment of the individual. According to Ernest Groman, head of the Nicotine Institute,

> *"one cannot expect anyone sitting there for three hours or more and answering the same 20 or 25 questions all over again. ... If someone really is committed to quit, he/she will also wait a few weeks or months until this meeting takes place".*[191]

The lack of support for quitters is, in part, a reflection of the emphasis over recent years on adolescents, and there seems little recognition that isolated measures are not – and cannot be – successful. As already noted, smoking rates among children and adolescents continue to rise, and many of these activities are patronising and/or targeting young people when they are already at an age where they will have started smoking. Cessation programmes for adult smokers seem to be politically less 'attractive' than youth programmes. Although the higher health care cost of smokers than non-smokers is known by the health insurance companies, they are still reluctant to provide financial support to these activities.

Much emphasis has been given to the 'flagship' project *Josefhof* ('Joseph Court') in Graz (Styria), an interdisciplinary, multimodal 20 day inpatient smoking cessation programme, developed and evaluated by the University of Vienna (Institute of Social Medicine and Nicotine Institute). It is usually presented as an activity of the Federation of Austrian Social Insurance Institutions. However, the *Josefhof* was actually founded by the miner's social insurance company in 1997 (and still belongs to this company). It is an institution for seriously nicotine-addicted individuals (Fagerström index >5) who already suffer from smoking-related diseases. The Vienna District Health Fund and some smaller insurance companies for certain occupational groups (miners, employees of the Federal Railways, industrial economy, and federal civil servants) have contracts with the miner's insurance company and send members there to aid cessation.[312]

[aa] Apart from Vorarlberg, where cessation programmes are 'advertised' in the media.

Between 2001 and 2003, 185 smokers with high levels of nicotine dependence have been recruited. The intervention consists of 34 hours of group treatment (25 participants) using a behavioural approach, individual counselling upon request and a accompanying sports and relaxation programme led by psychologists and sports therapists.[313] [314] During the three week stay, smoking is still allowed for the first week, followed by a psychological programme and ending with the signing of a "non-smoking contract".[315]

For members of the Vienna District Health Fund, access is difficult and it is considered to be a privilege to be allowed to participate. Every year, the Fund could send 100 severely ill nicotine addicts for a three-week treatment to the *Josefhof* in Graz; this yearly quota has not yet been achieved. For self-paying patients, the cost of the programme is €2,235;[312] if paid by the Vienna District Health Fund, the cost of therapy amounts to €1,620.30 per patient (June 2004).[315] Initially, the treatment (classified as cure) was free of charge to the patient. Now, as with other cures, the patient has to pay a small contribution *(Kurbeitrag)*, presently (June 2004) €6.19 per day if monthly gross income exceeds €653.20. The treatment is counted as rehabilitation and therefore as sick leave.[315]

The programme also offers follow-up assessments for one year.[bb] It claims an abstinence rate at completion of the course of 100% but by six months this has fallen to 55%.[315] After 12 months, 36% of patients are reported to be non-smokers, 24% have reduced their tobacco consumption, 13.5% still smoke and 27% have never presented themselves to any follow up assessments and are therefore classified as smokers.[313]

There are therefore no therapeutic activities whatsoever at national level and no plans for any in the future.[14]

At the regional level some of the District Health Funds can be identified as being more active in offering or supporting smoking cessation. Apart from the support of the *Josefhof* by the Vienna District Health Fund, the Upper and Lower Austrian District Health Funds must be mentioned *(see later)*. Among the remaining social insurance funds[cc], the fund for federal civil servants is undertaking a small amount of activity (in-patient cessation courses within a "preventive cure" concept, adopted from the *Josefhof* model), but the insurance fund for the Länder civil servants is inactive so far. This is even more surprising as civil servants are reported to have high smok-

[bb] After treatment, the Vienna District Health Fund also offers its residents who have participated a monthly *Jour Fixe* (one hour in the evening) for one year. The number of participants at these meetings is about 30 to 40.[315]

ing rates. Interestingly, the insurance fund for employees of *Austria Tabak* offers out-patient cessation and, in individual cases, bears the expenses for "medically necessary out-patient or in-patient smoking cessation".[316]

In 2003, the Lower Austria District Health Fund (NÖGKK) in co-operation with the Nicotine Institute in Vienna was establishing ambulatory services in Lower Austria. In summer 2003, four Lower Austrian towns offered outpatient treatment centres (one in every town) for smokers willing to quit. The treatment covers a period of five weeks and is paid by the District Health Fund, with only the nicotine-replacement (drugs or patches) being paid by the quitters themselves. It involves a combination of behavioural change and medication (single therapy, once a week). Every week, about 12 to 24 quitters get an appointment; by the end of 2003, about 500-600 smokers had participated. The Nicotine Institute claims a success rate of 80% after five weeks.[191] The Upper Austria District Health Fund offers three in-patient cessation centres based on the concept of the *Josefhof*.

Despite having the highest smoking rates, Vienna remains far behind. Although similar cessation centres have been proposed by the Nicotine Institute, this has not happened due to lack of financial support by the Vienna District Health Fund (WGKK) which is only willing to support its own few centres for smokers and the *Josefhof* in Graz. By comparison, the Lower Austria District Health Fund has agreed to pay for those attending the previously mentioned treatment centres from any province, as long as the numbers are not excessive.

The first smoking cessation activities initiated by the WGKK only started in 1997/98 when heavy smokers who wished to quit were treated in hospital. Only recently has ambulatory care (or rather, information) also been offered. By the end of 2003, however, only one centre offered both information and treatment; two centres offered only information, one being a chest clinic. The centres of the WGKK offer a smoker's anamnesis, the Fagerström Tolerance Test[dd] to measure exhaled carbon monoxide and grade dependence. This is free of charge, with only a referral from a doctor required. The official responsible for this programme at the WGKK reported that the organisation is more interested in the enlistment of organisations, such as schools or companies, to distribute information, or to be visible at public events (e.g. the fair for elderly people – perhaps a surprising choice) rather than investing in treatment programmes or advertising.[315]

[cc] Austria boosts 27 social insurance companies, headed by the Federation of Social Insurance Institutions. Health insurance is part of the social insurance system.

[dd] Karl Fagerström is closely related to Michael Kunze and Ernest Groman (see publications on smokeless tobacco).

The City of Vienna Health Authority has one 'advice centre' for smokers, open once a week between 15.30 and 18.00 for advice on smoking, nutrition and stress, all given by the same staff, including a secretary who gives 'common sense' advice on the telephone. It appears highly unprofessional, displaying a very formal attitude that can be seen as a deterrent by smokers seeking help. One official described the programme as having two parts: first advice from a general practitioner followed by advice from a psychologist. The approach is based on autogenic training and drawing on the work of Allen Carr. It is free of cost.[317] One person reported his experience at this centre as follows:

> "It was very short. The doctor said, I should put the money I would spend on smoking aside and set a goal of giving myself a real good treat – for example, buying a pair of expensive shoes. The psychologist said I should register at one of the Allen Carr seminars. I was really quite annoyed when I left because I have been reading this Carr book at least ten times over the last couple of years. It usually worked but I started again when being out with friends. Only this time it won't work, so I wanted to seek professional advice."

In the course of hospital treatment for heavy smokers with existing smoking-related disease, the "Medical Fitness Team" at the Lainz Hospital (Vienna) offers information, advice and support for cessation.[318] Some efforts are also made by the Institute of Environmental Hygiene of the University of Vienna to tackle smoking in companies.[319-322]

The level of activity in other provinces varies, the most active being Vorarlberg, where cessation programmes for adults have been running since 2001. Withdrawal programmes are part of a wider health programme and are offered throughout the province. They last three weeks, with sessions twice a week. On average, each group contains ten persons; however, the courses also run with fewer participants. Following the start-up phase there is now great demand and new courses are offered twice a month. Since autumn 2003 activities have been extended into companies, in a joint effort between the occupational medicine and health care systems, and linked to a programme to tackle obesity. There has been extensive media publicity. The courses cost €100 for each client and are not reimbursed by the health insurance scheme[ee].[323]

Upper Austria has eight locations offering smoking cessation support; Salzburg, Styria, Carinthia and Tyrol one each.

The already mentioned initiative *'Ärzte gegen Raucherschäden'* (Austrian Council on Smoking and Health) provides information on smoking-related issues on its website, and the programme *Jetzt Aufhören* ("Quit Now") offers a list of participating physicians. In theory, all general prac-

[ee] Except for one private complementary insurance company (UNICA) who contributes half of the cost.

titioners should also provide advice[272] but a lack of training means that this is not common and the involvement of health professionals in cessation is very modest.

Pharmaceutical treatments for tobacco dependence

In Austria, nicotine gum, patches and inhalators are available without prescription; these products are, however, only available in pharmacies, relatively expensive and – compared, for example, to the UK – not advertised (except that pharmacies display them in their windows). Bupoprion (Zyban), however, is a prescription drug, as is nicotine nasal spray. Ideally, pharmacological and psychological interventions should be combined. However, the lack of information in Austria on either approach has created little interest in either and for Pfizer (the market leader) the Austrian market is too small to invest in extensive advertising.

8.3.6 Illicit trade, smuggling

Especially in the eastern border areas of Austria, notably the Burgenland (bordering Hungary), cigarette smuggling is reported as an increasing problem. Other border areas in Lower and Upper Austria (Slovakia and Czech Republic), Styria (Slovenia), and Carinthia (Italy and Slovenia) are also affected, although to a markedly lesser degree.

It is reported from Austrian officials that, over the last three years, between 60 and 80 million cigarettes have been confiscated every year in Austria and the figure is increasing by about 20% per year. Large-scale activities are an increasing problem, presently accounting for 70% of the overall volume confiscated. Approximately 90% of the confiscated cigarettes are counterfeit brands made in China, mostly destined for the United Kingdom. Only about 10% of these counterfeit brands are destined for Austria. In total, the black market share in Austria is estimated to be no more than 10%.[324] [325] More detailed information on the issue of smuggling is in Appendix P.

8.3.7 Availability to young people

The widespread distribution of cigarette vending machines and the absence of sanctions against the sale, purchase or consumption of tobacco products to/of minors under 16 years means that children and adolescents are free to purchase cigarettes wherever and whenever they want to.

The 2003 symposium of the Austrian study group on addiction prevention in Carinthia focussed on tobacco. 120 experts demanded the establishment of a fund for addiction prevention, the drafting of a national action plan and a ban of cigarette vending machines. In October 2003, an

initiative to involve tobacconists in curbing sales to children was launched and test purchases by youths have also been planned.[326] However, in addition to this brief media report in an Austrian health magazine, no reactions to these appeals from the government can be recorded.

8.3.8 Monitoring, evaluating and reporting

In the absence of effective tobacco control policies, there is little need for monitoring. There is, however, information on smoking prevalence, as reported earlier.

8.4 Examples of smoking and no-smoking policies in Austria

In many industrialised countries there is increasing concern about the health effects of passive smoking. Not so in Austria.

The 1995 Tobacco Act, last amended in 2001 and 2003, restricts smoking in public buildings, schools and universities. The 1995 Employees' Protection Act, last amended in 2001, regulates smoking in the workplace. However, these regulations are not always adhered to. In addition, these regulations are rather weak, display considerable ambiguity, and are rarely enforced. The only area in which Austria has gone beyond the minimum required by EU law is an advertising ban in films aimed at young people (since 1995). Other films, however, are generally preceded by at least one cigarette advertisement (usually Memphis Blue). There is no clean indoor air law or any kind of regulation as to non-smoking areas in public places. Even the most recent amendments of the tobacco act contain no provisions for separated areas for non-smokers in the hospitality business.

In the area of voluntary agreement, where 'voluntary' often means the result of pressures against which opposition is no longer opportune (for example, pressure from international airlines landing in Vienna) or where economic interests predominate (for example, greater demand by non-smoking customers, or the expected reduction in cleaning costs), there have been some developments. For example, Austrian Airlines had to offer non-smoking flights and establish smoking restrictions on Vienna Airport, Austrian Federal Railways increased non-smoking compartments in trains, and smoking in underground stations has been banned since 17 April 1990 while in railway stations smokers are only asked to be considerate and kindly refrain from smoking, littering the place or annoying other people. Local public transport has banned smoking for a long time. In the restaurant business, voluntary arrangements are usually limited to

non-smokers' corners somewhere at the edge of the (usually least comfortable) room, or beside a draughty entrance, or beside the door to the toilets. These unattractive areas are not separated from the smoking area and can hardly be called a smoke-free environment.

Compared with the lobbying groups from industry (tobacco, hospitality, retail, paper manufacturing, advertising, etc.), 'lobbying groups' (in Austria rather the few dedicated individuals) in the field of health are small in number, weak and not organised (health ministry, anti-smoking advocates or associations). The lack of political will to implement tobacco control measures and the strong lobbying of the Austrian tobacco industry directed at policy makers, unions and the public (via the media), means that it is therefore often more correct to speak of Austria's 'smoking' rather than 'no-smoking' policies.

Overall, despite various commitments on the international level, Austria does not fully implement guidelines of the WHO with regard to tobacco prevention and protection of non-smokers and it even lags behind the minimum requirements of the European tobacco legislation. The following sections present some examples of why Austria is often called a smokers' paradise.

Smoke-free or smoke-full environments?

According to the 1995 smoking survey, 53% of the Austrian population aged 16 years and over are never-smokers and 17% are ex-smokers, at 70% in total representing a clear majority of non-smokers. In both cases the share of female non-smokers is even higher (total 77%). Adding the percentage of children and adolescents up to 15 or 16 years of age, those who suffer from bronchial asthma, heart disease, respiratory disease, or allergies, those who are pregnant or breast-feeding, and all those who feel annoyed or harassed by the smoking of others, this is a distinct majority of persons that should have the right to be protected from passive smoking. This figure may easily be compared to the 24% of daily smokers aged 15 or 16 years and over who claim their 'right' to smoke anywhere and anytime.[ff]

Women not only represent a higher share of non-smokers, they also report feeling disturbed and harassed by tobacco smoke more frequently *(Chapter 6; Appendix K)* and may also be more vulnerable to tobacco smoke (when pregnant or breast-feeding), both as active as well as passive smokers *(Chapter 7; Appendix L)*.

[ff] It must be said, however, that a considerable part of smokers would not mind refraining from smoking for an hour or two.

Despite all these facts, passive smoking and the health hazards resulting from it are not an issue of public discussion or political debate in Austria as yet, nor have they attracted any serious public health concern or great scientific interest. Where the issue is discussed it focuses on children, babies and foetuses (and thus also on pregnant women), as if these were the only ones needing protection. Although the health of children is always a politically attractive argument, it somehow diminishes the far-reaching effects of smoking on the entire population exposed to it.

Consequently, residents and 'spoiled' visitors to Austria who feel annoyed, disturbed or harassed by exposure to tobacco smoke and therefore try to avoid any contact with it will soon feel frustrated. For example, arriving at the Vienna train station in the evening, maybe after a trip in a non-smoking compartment where people just step outside to have a smoke in the gangway in front of the (sometimes open) door, the station is not only littered with discarded butts but there is smoke everywhere. Similarly when arriving at the airport one is confronted with so-called smokers' corners every few metres.[gg] Trying to get into town, it is difficult to find a non-smoking taxi (the driver may offer not to smoke during this trip) and, longing for somewhere to enjoy a dinner or drink, one will be disappointed to find not even one smoke-free facility (with the notable exception of the American chains McDonalds and the newly introduced Starbucks). Being pregnant or in company of children or babies, or suffering from asthma or having a cardiovascular condition affords no relief. In coffee shops one can find smoking mothers beside prams and see oneself surrounded by groups of smoking teenagers (especially girls). Among the famous Vienna coffee houses, only three were found to provide a non-smoking area (although not completely separated from the smoking section) and a few provide two or three tables located so unattractively that smokers would not want them. Complaints to the waiter would not help but rather result in a rebuke about why one is here and not staying at home if one is disturbed.[hh] At one's hotel, especially if it is a smaller one, asking if a room is a non-smoking room, one will be reassured that, of course, smoking is allowed anywhere.

In Appendix Q the present situation in Austrian public transport and the restaurant business is described in more detail.

[gg] That is, whenever the distance between the numerous pubs and cafés, where smoking is allowed, is too long.

[hh] What a waiter in a Viennese coffee house actually said was: "People have ALWAYS smoked in coffee houses, and this will never change. If you feel disturbed by the smoke, you must not go to a coffee house." *(Chapter 9)*

8.5 Discussion

Over the last two decades the Austrian government has launched a few small anti-smoking campaigns and related measures to combat smoking-related disease. However, since 1995, no campaign aimed at the whole population has been launched, nor are there effective anti-smoking measures or any concept of comprehensive tobacco control. Restrictions on smoking (partial smoking bans) in public places and workplaces do exist but are rather weak, not enforced, and not always adhered to. Smoking in restaurants, pubs and bars is subject to "voluntary agreement". Exposure of hospitality workers has not been a concern in Austrian health policy and even pregnant employees in the hospitality business are not protected effectively by any law.

Although Austria's restaurants, pubs, cafés, discos, etc. are known to be among the smokiest among EU countries, public awareness of the harm from environmental tobacco smoke is generally very low. Smoking in public places is strongly influenced (and successfully supported by the media) by associations with terms such as "personal choice", "one of life's joys", or part of "good living", while smoking bans are seen as "patronising" and "pleasure hostile".

Austria has not been inactive in tobacco control but, strikingly, out of all possible measures, it has chosen those that are known to be not very, or not at all effective. Apart from the Hospital Act, which has been regulating smoking in hospitals since 1974, and the regulation of smoking in public transport, all important laws with regard to smoking restrictions have only been enacted or "tightened up" either in connection with Austria's EU entry in 1995 or because they have been required by EU law. For example, the 1995 Austrian Tobacco Act, amended in 2001 and 2003, prohibits smoking in public buildings and establishments where young people were being educated or looked after (schools, etc.). The 1994 Employees' Protection Act, amended in 1999 and 2001, intends to protect non-smokers by "technical or organisational measures", such as heightened ventilation, local smoking bans and physical separation of smokers and non-smokers, "wherever this is possible".

Despite some regulations, Austria's attitude towards tobacco advertising is still very "relaxed" and sports events and football clubs continue to be sponsored by the Austrian tobacco industry.

Since 1998, starting with an industry-funded campaign, the chosen measures have been focussing exclusively on youth campaigns, aiming to prevent the up-take of smoking by youths. The predictable failure of these small-scale, isolated and mostly unattractive campaigns is reflected

in the continued and alarming increase of smoking prevalence among youth over recent years, making Austrian teenagers (especially girls) rank among top within EU countries. No efforts are put into information and support of smokers in relation to cessation and existing cessation services are few in number and often unprofessional. Accordingly, awareness of and interest in cessation is low among smokers. Furthermore, even advertisements for nicotine replacement therapy are virtually non-existent, as it is not profitable for the pharmaceutical industry due to lack of demand. Of course, demand would increase after the launch of population-wide and effective anti-smoking campaigns within a wider set of comprehensive measures.

In summary, the measures adopted to reduce smoking rates and prevent people from taking up smoking must be assessed as largely ineffective and lacking any kind of conceptual underpinning. The extremely industry-friendly approach towards tobacco policy seeks to maintain the smoker-friendly environment, a trademark Austria has long been internationally known for. As the Austrian government does not see any problem with its tobacco control policy, avoiding any unnecessary action and focusing on its meagre youth-campaigns, it may be assumed that the existing situation will continue for some time.

Having examined the initiatives to reduce tobacco consumption that exist in Austria, the following chapter examines the role of the key actors in Austrian tobacco policy and attempts to discover why some measures have been taken and others not.

9 ACTORS IN AUSTRIAN TOBACCO POLICY

9.1 Introduction

This chapter seeks to identify policy actors in Austrian tobacco policies, describing their understanding of smoking policies, determining their position, interest and influence on this issue, and identifying their inter-relationships. Discussions with key informants and key actors, analysis of media reports, and analysis of policy measures are used to analyse the role of Austrian tobacco industry and the Austrian government with regard to past and present tobacco policies. The chapter concludes with an overall analysis of Austria's tobacco policies.

The most dominant actors in Austrian tobacco policies are the national government (including several ministries: health, finance, economics and labour, sports, education, labour, and social affairs) and the tobacco industry with its main ally, the hospitality industry, but also the advertising industry. The media have been recognised to be an important opinion leader by disseminating mostly industry-friendly arguments particularly over the last two decades. Thus they have created a pro-smoking climate in the population. There are, of course, other potential actors, such as national and regional associations or organisations engaged in health promotion and tobacco control, local governments, non-smokers' associations, or other NGOs such as the Austrian Cancer Society. However, as political support is lacking and public awareness is underdeveloped, their role is very limited and their activities have had little effect on the government's tobacco control strategy. Besides, the role of some so-called anti-smoking advocates is not transparent.

In general, Austrian policy making may be characterised as the result of a close circle of persons of various interest groups, mostly well known to each other, partly even cordially related as 'old pals'. With regard to tobacco policy this is expressed by displaying mutual benevolence and tolerance, and preparedness to let the other play his part in the game as long as it does not result in any disadvantages for the other party. Some of the key actors are reported to play on both sides of the field. In addition, as outlined in the preceding chapter, laws to restrict smoking are interpreted in a rather lax fashion in Austria.

Austria's tobacco policy must also be seen in the context of its overall health policies, which are characterised by a lack of consistency. Apart from the fact that the post of a Minister for Health (as with Ministers for Social Affairs) is not always the most rewarding one, being pro-

vided with a very limited budget while facing seemingly ever increasing costs, the frequent shift of the health agenda from one ministry to another and the frequent exchange of health ministers (and often also of key officials) have resulted in a lack of continuity, also seen in Austrian tobacco policies. Campaigns have been very short and have been addressed exclusively at 'politically attractive' target groups (children and youths). Since 1994, no health politician has been deeply engaged in tobacco control.

9.2 Role of Austria's tobacco policies

9.2.1 Tobacco policies in Germany and Austria in the 1930s and 1940s

Unlike Germany, where the equally strong pro-smoking climate has been explained by some by historical events, i.e. the strict anti-smoking regulations during the Nazi-era[327], Austria's reluctance to adopt any kind of enforceable law requires a different explanation. As shown in Appendix R, these arguments are based on a misjudgement of the situation in Germany, with persisting stereotypes. While most arguments may not even be applicable to Germany, they certainly cannot be applied to the situation in Austria. However, they have entered the Austrian media and have been readily taken up by the public and, at least indirectly, by health politicians.

It is thought, however, that the cultivation of this artificial justification helps to impede an engaged tobacco control policy in Germany and Austria. The implied but unwarranted linkage of all kinds of tobacco control measures with authoritarian Nazi-methods are in the interest of the industry, which could not have found a better argument.

9.2.2 Austria's policies in the international field

In the early 1990s, in particular during the term of Health Minister Michael Ausserwinkler, Austria was reported to be among the pioneer countries at WHO talks on tobacco control. Within the Austrian government there was even a consensus about tobacco control policies. Then an order came to abstain from this pioneering role, the strongest opponents being Victor Klima and Wolfgang Schüssel *(Section 9.4)*, both representing strong economic interests.[277]

In the late 1990s, during the development of European tobacco control legislation, Austria did not exactly cover itself in glory. Loyally on the side of Germany, it voted against the compre-

hensive advertising and sponsorship directive (98/43/EC), which subsequently was annulled by the European Court of Justice in 2000 *(Chapter 5)*.

However, things have changed again over the last years. Being no longer opportune, Austria has not exactly changed sides but tries to refrain from developing visibility on this issue. At least it did not oppose the recent EU advertising ban, as did Germany. The reasons for this change, which took place in November 2000 with the new conservative coalition government, were very difficult to elicit, as nobody seemed to remember, it being "too long ago". Nevertheless, an official from the press office of the State Secretary of Health put it quite bluntly and showed the Austrian approach to this issue:

> *"This was so long ago, honestly, I can't remember at all... Initially we did not want to criminalise smokers. Besides, that would have been – as with all advertising bans – an enormous danger for the economy. But we promised our support in November 2000. The reason was that the hitherto strategy was unpromising."*[328]

Presently, Austria's strategy in the international arena distinguishes itself by a certain ambiguity. While one is always ready to raise its hand or sign a declaration – as long as it is noncommittal, of course – to demonstrate some sort of interest and conformity (after all, one does not want to be a dog in the manger), things look different 'at home'. As with other issues agreed upon in meetings of the European Community, there is a tendency among Austrian politicians to present Austria as the poor victim of the 'bad' and omnipotent EU who imposes all these things upon us. For example, Austria signed the Warsaw Declaration and the Framework Convention on Tobacco Control (28 August 2003), but there are no signs whatsoever of implementing any of the proposed measures. Quite the opposite, all these measures have been somewhat ridiculed and criticised for being "too extreme" *(see later)*. The implementation of directive 2001/37/EC only took place in October 2003, after a rebuke from Brussels *(Chapter 8)*. At the same time, when necessary, Austrian health politicians do not tire from pointing to Austria's "active role" in international tobacco control committees *(Section 9.4)*.

Consequently, it would seem more correct to describe Austria not as a player but a cautious watcher in the international field of tobacco control. However, the threat posed by Ireland (whose EU presidency emphasised tobacco control) as the first country in the EU imposing a total smoking ban in all public places in March 2004 and also its transgression of the minimum labelling guidelines were obviously so great that Austria was shaken out of its cautious state. Again on the side of its old ally Germany and driven by the Ministry of Economics, it demonstrated its opposition to what might become exemplary for other European countries, in particu-

lar by objecting this generous interpretation of the EU labelling guidelines (which also extended to other product groups) as a technical trade barrier.[329]

9.2.3 Recent tobacco policies and policy climate in Austria

Tobacco policy has had no real priority for many years and, until recently, there has been no public debate of anti-smoking measures. Only in October/November 2003, following the introduction of enlarged health warnings on cigarette packs, and in the beginning of April, following the implementation of the Irish smoking ban, the Austrian public was aroused for a week or two and health politicians were forced to react. Some public discussion started, mostly expressing dismay or lack of understanding of these exaggerated measures, but things soon returned to normal.

Before attempting to give an overall analysis of Austria's tobacco policies, the key actors and their roles in the decision-making process are described in the following section.

9.3 Actors and their roles in Austrian tobacco policy

The key actors in Austrian tobacco policy have been listed earlier and include the Federal Government with various ministries and the Austrian tobacco industry with its economic allies (in particular the hospitality and the advertising industry). In a wider sense, one would also have to add the seemingly industry-influenced Austrian media for disseminating mostly smoker-friendly opinions and, in the sense of a conspicuous abstinence from action, some self-proclaimed anti-smoking advocates. The public, or rather, public opinion, is another important influential factor for political decision-making.

The core group of actors, consisting of representatives of the government and the tobacco industry as well as some opinion leaders and former government consultants, is characterised by a small and often very close circle of individuals, despite their allegedly different interests. Information as to the kind of relationships of these key players was very difficult to elicit as policy-oriented questions were directly or indirectly declined; in one case the researcher was given to understand that it would be better for her "not to play the detective" (as it proved, a well-founded concern). However, from what is known and has been confirmed by informed circles, most actors have been personally, economically, or party-politically related for a long time, sometimes very closely, and sometimes even so closely that it has become difficult to determine

on which side they operate. In the course of searching industry documents, evidence was found that substantiated rumours about "financial incentives" for obliging scientists and self-proclaimed opinion leaders. However no firm evidence could be found concerning party donations given by the Austrian tobacco industry.

On the other hand, although not answering all questions put to them, the 'good citizen' *Austria Tabak* – following the new approach by the industry, defined by 'communication with society' and 'social responsibility' – was rather compliant in providing information, after enquiring about the purpose these data are needed for and details of the thesis (name of University and supervisor).[a]

Without expecting Austria to come up with many high-calibre anti-smoking activists to engage in tobacco policies on the highest political level such as, for example, the *cinq sages* in France[141], the overall climate in Austrian tobacco policy is a self-righteous consensus, accentuating the tolerance in Austria and the "good conversational basis" between all parties concerned. Certainly, nobody would embark on a collision course on either side.

To provide a better understanding of the decision-making process in the government, the most influential key player, the tobacco industry with its allies, will be presented first.

9.3.1 Austrian tobacco industry and allies

Austria's tobacco industry consists of the until recently state-owned tobacco company *Austria Tabak* (now *Austria Tabak – Gallaher Group Plc*); its subsidiary *Tobaccoland Austria*, and the representation of Austria's tobacconists, *Monopolverwaltung GmbH* (Monopoly Administration Ltd.). Incidentally, the laboratory ÖKOLAB, which has been commissioned by the Austrian government to control the constituents of tobacco (in particular cigarettes) is also a subsidiary company of *Austria Tabak* (although, curiously, this fact seemed to be 'unknown' to all health politicians and government officials questioned).

In a confidential 1979 Philip Morris report one can read about the "good access" of the Austrian tobacco company to "all of the media, prominent scientists and MDs *[medical doctors]* and members of government and parliament"[104]. Although there are some changes since the privatisation of the company, the "good relationships" between all parties are maintained.

[a] Interestingly, the only others that asked these questions were three leading so-called anti-smoking advocates, two of whom were subsequently too busy to find time for a meeting.

Research on smoking and health has been supported by the Austrian tobacco industry for many years (as reported by M. Kunze already in 1974[330]) and the influence of the Austrian tobacco industry on the government's policies has been known to be very strong. Top representatives of *Austria Tabak* have always been involved in preliminary governmental discussions[277] (in particular with regard to regulations on taxes and prices, but in some cases also in the planning stage of campaigns[b]). Even today, the tobacco company, the hospitality industry and the advertising industry are seen by politicians as the main parties the government would have to 'negotiate' with in relation to any move on smoke-free environments.[298]

The Austrian media have been equally influenced. Being a very important advertiser, the company has been using the Austrian media for both indirect advertisement[c] and dissemination of industry friendly arguments *(Section 9.3.8)*.

Austria Tabak has also been known for its very high advertising expenditure on smoking campaigns (thus creating economic allies in the advertising business) and sports sponsorship (acquiring allies in sports clubs, in particular football clubs; Formula One; presently also sponsor of the Austrian Ski Team).

Beppo Mauhart, General Director of *Austria Tabak* before privatisation, has certainly been the most striking figure in the history of the company, its advertising strategy and, in particular, its close involvement in all tobacco-related activities of the Austrian government. Prior to his career in the tobacco business, Mauhart, an economist, was employed in the Ministry of Finance (1970-1972), working as secretary of the then Finance Minister (and later Vice-Chancellor) Hannes Androsch, the latter known as the 'crown prince' of Chancellor Bruno Kreisky. In 1972, he was appointed to the Board of Directors of *Austria Tabak* (then *Austria Tabakwerke AG, ATW)*. In 1976, he became Vice Chairman and between 1988 and 1995 (under Federal Chancellor Franz Vranitzky) he was Chairman of the Board (General Director). He has always maintained strong party-political ties and close personal relationships to senior members of the Austrian social-democratic government (in particular to his former colleagues and friends Hannes Androsch and Franz Vranitzky) and has been noted for his "excellent lobbying".

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[b] As, for example, was the case under Health Minister Christa Krammer (SPÖ).[331]

[c] Recent examples for indirect advertising can be seen in an article in the economic section of the *Kurier*, the second most sold daily Austrian newspaper, where new "cigarette creations" (the two new brands *Silk Cut Ultra* and *Silk Cut Ultra Mild*) and the economic success of the Austrian tobacco company are elaborately praised[332], or in the cover story of the Austrian news magazine Profil[265] *(Section 9.3.8)*.

In addition, while directing the Austrian tobacco company, sports enthusiast Mauhart was also President of the Austrian Football Union between 1984 and 2002. Accordingly, *Austria Tabak* was (and still is) a main sponsor for sports clubs (in particular football clubs) and sports events. Still today, Mauhart prides himself on the 144 international matches played under his presidency.[333]

Beppo Mauhart was very skilful in marketing not only cigarettes, but also his person, having millions of Austrian Schillings of advertising budget at his disposal. There was hardly a beauty contest, a private art viewing, a football game, or a high society meeting where he did not appear as *'Mr. Tschick'* (Tschick = fag). He has had excellent relationships with opinion leaders in the media, these being permanently strengthened by generous advertisements by the tobacco company. His power has become much greater than the Health Minister's and his influence was noticeable in all public decisions. In 1992, with the war in Yugoslavia, another component of his power, this time of a social nature, was added: the Austrian tobacco company supported the initiative *'Nachbar in Not'* ('Neighbour in Distress') by sponsoring ten lorries. This led to television portrayal of him as a benevolent sponsor, an effective contribution to indirect advertising. Mauhart's connections even reached into the Austrian justice system *(Footnote l below)*.[334]

Still today, despite his resignation almost ten years ago, Mauhart has been invited to television discussions on anti-smoking *(sic)* measures[d] as *the* "advocate of smokers", *the* representative of the Austrian tobacco industry, and *the* expert in anti-smoking policies par excellence. As his statements clearly dominated both discussions, they will be presented in Section 9.3.8 and Appendix V. In February 2004, he was awarded by the head of the provincial government of Lower Austria, Erwin Pröll, "one of the highest awards the province of Lower Austria has to offer". Mauhart, so Pröll said, had "used his talents in all his functions in economy and sport", thus making tremendous achievements for Lower Austria.[e] The celebration was attended by numerous friends, including sports journalists, former national football players, and politicians.[333]

For years Beppo Mauhart maintained the industry position that tobacco advertising did not target young people but only supported the maintenance of market shares and helped people (people, not only smokers!) to choose less risky cigarettes. He also argued that in countries with an

[d] One following the introduction of enlarged health warnings in November 2003, the other following the implementation of the smoking ban in Ireland in March 2004 *(Section 9.3.8)*.[37 38]

[e] Pröll referred to Mauhart's merits as General Director of *Austria Tabak* for securing one of its sites in an economically particularly weak region and his function as president of the Austrian Football Union, for sponsoring the Lower Austrian football association.[333]

advertising ban tobacco business had actually increased and that, without smoking, much worse dependencies (drugs) would occur, an argument which effectively has become ingrained in public opinion. The Austrian media have continuously repeated these views. Even health politicians and economists are influenced by this 'sound' argument. The "confrontation" between smokers and non-smokers has therefore been created systematically. Besides, the fact that Austria's tobacco policy has more or less been unchanged since the 1970s is a visible result of this underlying paradigm.[334]

As already noted in Chapter 3, *Austria Tabak* (under Beppo Mauhart) even published a brochure[f] for its employees on arguments on smoking and health in 1982, destined for the company's employees as "balanced information" and an "argumentation basis" for "talks with friends and acquaintances, in discussions" (including rules for conducting talks to achieve a "controlled dialogue"). Apart from many arguments, often based on "scientific proof"[g] which can still be recognised in public opinion and which were still used by Mauhart in recent TV discussions,[h] the focus of this briefing is on the responsibility of the firm to develop and sell "the modern, light cigarette".[71] The reader is also reminded repeatedly that all this is a matter of tolerance – or rather: the problem of intolerance from the part of non-smokers[i] – and, of course, good ventilation:

[f] A special edition of the internal news magazine *Austria Tabak Information.*

[g] By citing, for example, Ernst Wynder, Peter Lee (the statistician who once worked with Richard Peto) and Michael Kunze.

[h] Arguments: Tobacco would be a luxury good like tea or coffee, every culture would possess its specific stimulants and their consumption would be something specifically human, the sum of all vices would remain constant, cigarette smoking being described as "pure enjoyment" which would be "difficult to describe" but had "undeniably positive effects", no "chain of causality in the strictly scientific sense between cigarette smoking and illness", all being a "question of mutual consideration and tolerance (and of ventilation)", distinguishing "tolerant" non-smokers versus "fanatical anti-smokers", freedom to decide whether, "to improve the quality of life", "adult and articulate people in this country" should "continue to consume a stimulant that for centuries has been a component of our civilisation".[71]

[i] To illustrate the importance of tolerance against the "dealers in anxiety" (fanatical anti-smokers), the Austrian-American psychiatrist Professor Friedrich Hacker is cited with a remarkable insight: "The psychoterror of everyday life is from us and in us. The infectious bacillus of intolerance contaminates our environment and poisons our interior world with horrifying images of anxiety". [71]

> "As two scientists from Harvard University, USA, were able to show, it was necessary to spend 100 hours without interruption in a smoky bar in order to breathe the smoke contents of one single filter cigarette. Thus if smokers are together with non-smokers who feel troubled by the smoke, this becomes a question of mutual consideration and tolerance (and of ventilation). Smokers and non-smokers (as distinct from fanatical anti-smokers) can get along together very well. Both sides should make efforts not to allow walls to be erected between them, with every conceivable type of decree and regulation."[71] [j] *[Orig. translation]*

An appeal, apparently only for heavy smokers, is made to be "particularly considerate in the presence of small children and asthmatics, or in rooms that are difficult to ventilate (e.g. lifts or similar spaces)".[71]

This "active part in the smoking-related issues" of *Austria Tabak* – despite its sometimes "unorthodox" views – was positively mentioned at the Infotab meeting in Bath 1983. The reference also indicates the opposition against Health Minister Salcher's efforts to ban advertising *(see later)*.[k]

> The Austrian Tabakwerke "has taken an active part in the smoking-related issues and strongly defended its position in a National Assembly resolution of July 3, 1980 to ban advertising. It has also produced a guide to the smoking and health question for its employees.
> ...
> "The monopoly's views on certain smoking-related issues are unorthodox and would be rejected on legal issues by INFOTAB members. Nevertheless, interest in the basic issues is quite strong."[105]

Hospitality industry

As in most other countries, the hospitality industry in Austria has been a close ally to the tobacco industry. Successfully convinced by the tobacco industry that smoke-free environments would ruin business, and in turn successfully convincing politicians of a dramatic economic impact on the state, both Austria's hospitality industry and politicians are strictly opposed to any kind of legal smoking restrictions in public places such as restaurants and cafés. Arguments are directed towards "voluntary agreements" and the installation of "good ventilation".

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[j] To demonstrate the futility of smoking restrictions, it is continued with the following example from the United States: "In Seattle, USA, for instance, two restaurants introduced non-smoking zones. After one month, 9,389 meals had been served in the smoking zone and only 21 in the non-smoking zone. In another, out of 17,421 customers, only 23 asked to be separate from smokers."[71] Without wishing to comment on this "example", one is reminded to the present situation in Austria: As hardly any non-smoking zones or rooms are offered, nobody asks for them and those who ask are soon discouraged by the way the answer is given *(see later)*.

[k] This reference provides also information on the contacts between INFOTAB, the Verband (of which *Austria Tabak* was a member) and the monopoly. "Indirect contacts between INFOTAB and the Austria Tabakwerke have been made via the Verband, and informal direct links through Dr. Zimmel, the Public Relations Manager." It was felt desirable that "more regular informal contacts should be developed with Dr. Zimmel either directly or through the Verband". [105]

Industry-funded associations

The Austrian representative of Forces International, "*Verein der Toleranz* (Association of Tolerance) – Forces Austria" advertises itself as a smokers' rights group, fighting the "criminalisation" and "discrimination" of smokers[l] through a possible future threat of smoking bans in restaurants and bars "even in Austria". The arguments made are either similar to those from the anti-smoking side (e.g. ignorance of smoker-friendly articles in the one-sided, i.e. non-smoker-friendly media – *sic*) or consolidate the confrontational image of smokers and non-smokers by using militant language. It accuses the EU of having an economy-devastating approach, the "ever so respectable" WHO of manipulating the public, "probably in the interest of the pharmaceutical industry", and dwells on causes with "much greater" risks of dying, such as alcohol, HIV, and road accidents. Not missing the opportunity, it also hints at a certain fanatic leader in the past and the association between anti-smoking measures and a totalitarian state: Between two pictures of Albert Einstein (or someone who looks like him) the big slogan says: "Better a smoking freedom than a non-smoking tyranny".[m]

Smoking bans in restaurants and bars are seen as a particular threat to both "freedom of choice" of the smoker and the economy. According to this propaganda, "numerous bankruptcies and loss of employment for many" are to be feared.[335]

9.3.2 Government, ministries, governmental organisations

The government and its various ministries with their respective representatives is the official key actor in Austrian tobacco policy. The ministries most involved in the decision-making process are the Federal Ministries for Health, Finance (taxes and shares), Economics (hospitality industry and various other economic interests), Education (schools), Labour (employees' protection), and Sports (sponsorship).

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l Interestingly, the terms "criminalisation" and "discrimination" of smokers seem to be very popular among both industry representatives and health politicians.

m Citation: "Due to current political manipulations (in particular by the economy-destructive EU) and the present 'witch hunt' against smokers, the VdT *[Verein der Toleranz]* as the Austrian Club of 'Forces International' has determined to work in the future! Fortunately, most people, including non-smokers, are tolerant! Only, unfortunately, there are a few fanatics who can make a lot of noise and probably even bribe politicians *[sic]* – but democracy has something to do with majority and the majority in Austria, for example, is against any smoking bans, particularly in the hospitality business."[335] *[Translation by the author]*

Federal Ministry of Health

For the first time in 1972, a ministry dealing with the health agenda was established, named the Federal Ministry of Health and Environmental Protection. However, it was only 15 years later that a separate Minister was allocated the health agenda (1987-1990). This represents a notable exception as, since then, matters of health have always been associated with social or environmental affairs. In fact, the Ministry has changed names more or less after every election, being attached to various other ministries *(Table 9-1)*. In 1997, the Health Ministry was dissolved entirely and most of its responsibilities were taken over by the Ministry of Social Affairs. It is only since 1 May 2003 that there has again been a separate health ministry, called the Federal Ministry for Health and Women.

Over this period, numerous health ministers have appeared on and disappeared from the scene. With a few exceptions they usually held their office for a short term, sometimes only for a few months *(Table 9-1)*. This and the fact that it is one of those ministries which in coalition governments are usually given to the less powerful party (or to female ministers), reflects not only its unpopularity but also its low status. The position of the Health Ministry is also characterised by its having to stand up to the interests of other ministries (particularly the Ministry of Finance and the Ministry for Economics). In addition, these frequent changes contribute to the lack of continuity within Austrian health policies in general and tobacco policies in particular.

Table 9-1 Austrian Health Ministers since 1972 (status April 2004)

Name of Minister	Political party	Term of office from	to	Duration of term	Name of Ministry
Dr. Ingrid Leodolter *(physician)*	SPÖ[1]	2. 2. 1972	– 8. 10. 1979	6 years, 8 months	Federal Ministry for Health and Environmental Protection (1.2.1972 – 1.2.1989)
Dr. Hertha Firnberg *(social history & history of economics)*	SPÖ[1]	8. 10. 1979	– 5. 11. 1979	1 month	
Dr. Herbert Salcher *(jurist)*	SPÖ[1]	5. 11. 1979	– 20. 1. 1981	1 year, 3 months	
Dr. Kurt Steyrer *(physician)*	SPÖ[1]	20. 1. 1981	– 17. 12. 1985	3 years, 11 months	
Franz Kreuzer *(TV journalist)*	SPÖ[1]	17. 12. 1985	– 21. 1. 1987	1 year, 1 month	
Dr. Marilies Flemming* *(jurist)*	ÖVP[2]	21. 1. 1987	– 31. 3. 1987	2 months	
Dr. Franz Löschnak *(jurist)*	SPÖ[1]	1. 4. 1987	– 2. 2. 1989	1 year, 10 months	
Harald Ettl	SPÖ[1]	2. 2. 1989	– 3. 4. 1992	3 years, 2 months	Federal Ministry for Health and Public Services (2.2.1989 – 1.2.1991)
Dr. Michael Ausserwinkler *(physician)*	SPÖ[1]	3. 4. 1992	– 17. 3. 1994	2 years	Federal Ministry for Health, Sports and Consumer Protection (1.2.1991 – 12.3.1996)
Dr. Christa Krammer *(political science)*	SPÖ[1]	17. 3. 1994	– 28. 1. 1997	2 years, 10 months	Federal Ministry for Health and Consumer Protection (12.3.1996 – 15.2.1997)
Eleonore Hostasch	SPÖ[1]	28. 1. 1997	– 3. 2. 2000	3 years	Federal Ministry for Labour, Health and Social Affairs (15.2.1997 – 1.4.2000)
Dr. Elisabeth Sickl *(study of law and high school teacher)*	FPÖ[3]	3. 2. 2000	– 24. 10. 2000	9 months	Federal Ministry for Social Security and Generations (1.4.2000 – 1.5.2003)
Herbert Haupt *(veterinary surgeon)* and State Secretary Dr Reinhart Waneck *(radiologist)*	FPÖ[3]	24. 10. 2000	– 28. 2. 2003	2 years, 6 months	
Maria Rauch-Kallat *(secondary school teacher)* and State Secretary Waneck[4], *FPÖ*	ÖVP[2] FPÖ[3]	28. 2. 2003	– dato		Federal Ministry for Health and Women (since 1.5.2003)

* Consigned to the direction.

1) SPÖ = Social Democratic Party of Austria.
2) ÖVP = Austrian People's Party.
3) FPÖ = Freedom Party of Austria.
4) Until beginning of July 2004 when the State Secretariat of Health was dissolved.

Source: Information from the Austrian Health Ministry.

Two Austrian health ministers have been very interested and active in tobacco policies, despite their short term of office. These were Dr Herbert Salcher (a jurist from Innsbruck/Tyrol) and Dr Michael Ausserwinkler (a physician from Klagenfurt/Carinthia). The first Austrian Health Minister, Dr Ingrid Leodolter, has tried to promote anti-smoking legislation but without success. A 1979 Philip Morris report described her as "a weak politician and her policies are in conflict with those of the Minister of Finance, Mr. H. Androsch, who is also in charge of the Austrian tobacco monopoly".[104] It was also clear that anti-smoking legislation would require a change in the Constitution and thus the legislative situation remained unchanged until 1995.

Herbert Salcher, Austria's Health Minister for just over a year (November 1979 to January 1981, SPÖ), started the first Austrian anti-smoking campaign in 1980. He gathered a young team around him, consisting of scientists (Michael Kunze), a popular radio speaker (Rudi Klausnitzer), artists and athletes and secured strong media support by keeping up intense contacts to print, radio and television journalists.[305]

In the discussion Minister Salcher seemed unaware of the double-role of Michael Kunze, appreciatively describing him as a "publicity genius" and the first expert in this field, taking health education seriously.[305] At that time, Kunze seemingly already received funds from the Austrian and German tobacco industry *(Appendix U)*. Thus he was not only a "publicity genius" but, by working for both sides, also economically and tactically very clever *(Section 9.3.3 and Appendix U)*.

Objecting to any kind of prohibition or an aggressive campaign "spreading horror", as in other countries, Salcher and his team wanted to initiate a campaign against smoking, not against smokers, thus promoting a positive image for non-smokers.[336] Designed as a whole programme or package, this campaign should be a first, psychological step to create awareness and gain the consent of people.[305] Results of studies which accompanied the campaign showed that – as a short-lasting effect – smoking rates among men declined slightly while rates among females still increased.[305] Nevertheless, considering the short term of the Health Minister and the very short time of this campaign (only about 6 weeks), this initiative was very successful *(Chapter 8 and Appendix O)*.[a]

[a] Thus already in 1980, when the first anti-smoking campaign was launched, concerns were expressed about increasing smoking rates among young people, especially among young women. However, although the Health Minister already pointed to the health hazards and the harassment of passive smoking in 1980, emphasising that non-smokers had to be protected, it took another 15 years to adopt the Tobacco Law with at least a few weak regulations.

Although Salcher welcomed the then emerging trend for 'light' cigarettes, which were reported to be less harmful, from a health policy point of view, he objected to a proposal from the then *Austria Tabakwerke* to conduct joint action in support of 'light' brands. In his opinion, smoking had to be combated at its roots; 'lighter' smoking, so Salcher argued, would not lead to anywhere and, in accordance with the Surgeon General's Report, a 'healthy' or 'safe' cigarette could not exist.[337]

Salcher also proposed warning labels on cigarette packs, a proposal continued by his successor, Kurt Steyrer. However, the latter could not stand up to the various interest groups and thus the thread was lost.[305]

Another element in Salcher's anti-smoking campaign was the fight against cigarette advertising, an effort which seemed quite promising at the beginning. However, the Austrian tobacco company with its then General Director Deputy, Beppo Mauhart, beginning to feel a kind of 'stiff breeze', soon took steps to stop this. A National Assembly resolution regarding a whole package of measures, including warning labels, advertising bans, etc., was declined – by only one NA member: Hannes Androsch, then Finance Minister and official representative of the Austrian tobacco company. This success for the company was even appreciated in a senior executive meeting of the international tobacco industry[105] *(see citation above).*

It is noteworthy that, according to the discussion with the Health Minister in 2004, this advertising ban was only thought as a basis for discussion. Like later Franz Löschnak, Salcher had been convinced that an advertising ban would not have been feasible because of the German magazines and newspapers being distributed in Austria. "We did not want to be at war with all newspapers".[305]

Although Chancellor Bruno Kreisky (SPÖ) was in accordance with Salcher, he needed an assertive Finance Minister and thus the term of office of the Health Minister was rather short. However, under Salcher's office as Finance Minister and thus representative of *Austria Tabak*, Mauhart did not ascend to the position of a General Director. Salcher had chosen Leidinger who was considered a better option for the company, where "one would not need a trouble maker". It was only when Franz Vranitzky, a close friend of Mauhart, came to power that the latter became General Director of *Austria Tabak*, in 1988.[305]

Still, due to the weakness of subsequent health ministers, Kurt Steyrer[b], Franz Kreuzer, Franz Löschnak, and Harald Ettl (all SPÖ), Beppo Mauhart had no more obstacles to his advertising strategy which became more and more aggressive under his reign. None of the health ministers undertook any serious attempts to restrain the 'Tobacco General' during his hegemony. It was Michael Ausserwinkler (1992-1994) who had the courage to step up. As a physician he knew the issues but as a politician he lacked allies. Even his own party friends helped to strip down his planned comprehensive tobacco law *(see later)*. Finally, Chancellor Franz Vranitzky (SPÖ) declared: no tobacco advertising ban, no sanctions, and everything to remain more or less the same. This was a clear victory for Beppo Mauhart and the Austrian media.[334]

In 1988, although the potential health hazards from passive smoking were already known for many years (at least in informed circles), Health Minister Franz Löschnak (SPÖ) still seemed unconvinced.[c] He initiated a scientific meeting to ask whether passive smoking would indeed cause any health risks. This was the so-called *Passivraucherenquete* (Passive Smoking Hearing) *"Krank durch Passivrauchen?"* ("Ill by passive smoking?"), held on 3 May 1988. This meeting was not only sponsored but also participated in, influenced and, in fact, organised by the Austrian tobacco company, as several industry documents show *(Appendix S)*. [339 340]

Participants were mostly known for their industry-friendliness or 'harmlessness', some even have been working for the industry for many years (as, for example, Wynder, Überla, Adlkofer, etc.). Participants came also from the Austrian tobacco company (General Director Beppo Mauhart and the head of the company's research unit, Dr Klus, who was also one of the speakers and main organisers). Speakers and participants were proposed or approved by the tobacco industry (i.e. *Austria Tabak* and Philip Morris). Most of the industry-proposed speakers came from Germany and the United Sates. Among the proposed Austrian experts were Michael Kunze and Christian Vutuc *(Appendix S)*.[d 339 341]

Not surprisingly, the results of this meeting, as presented by Löschnak to the press shortly afterwards, were poor: there was no proof of anything, and therefore one could do nothing (or hardly anything) against the harassment of non-smokers. The scientific methods would not yet be elaborate enough to assert a relationship between diseases and passive smoking, so said

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[b] In 1988, the former Health Minister Kurt Steyrer was also chosen by *Austria Tabak*, the real organisers (behind the scene) of the Passive Smoking Hearing, to preside the hearing on the side of Health Minister Löschnak.

[c] Already in 1987 Health Minister Löschnak's statements with regard to passive smoking, smoking bans, etc. seem to anticipate the findings of the hearing taking place one year later *(see Appendix S)*.[301 338]

[d] It was not possible to obtain a full list of participants (or any detailed information about this meeting) from sources in Austria. The Philip Morris archive, however, proved more successful. *See Appendix S.*

Löschnak. However, at the symposium itself some scientists seemed to be of a "controlled"[e] different opinion. Agreement was only achieved about the issue of dangers for unborn babies and children. It was recognised that children of smoking mothers had a higher risk of premature birth, a lower birth weight, and are more susceptible to bronchial diseases and pneumonia in their first year of life. Infants and employees would have to be protected from tobacco smoke. Asked if he would set an example within his own department, Löschnak replied smilingly to the horde of puffing journalists that, at the next press conference, he would hang up a poster advertising the protection of non-smokers. This, so Löschnak said, should demonstrate that "one just could not regularise and execute everything". Löschnak would only become active against the smoking rooms in schools, whose existence were heavily criticised by many participants at the symposium. However, returning to the usual Austrian attitude, should it not be possible to disestablish the smoking rooms, one would at least launch an educational campaign in the schools.[342] (Obviously, it was not possible, as it was only in 1995 when smoking rooms in schools were abolished by the Minister of Education, Erhard Busek (ÖVP). The first youth campaign was initiated in 1990.) Löschnak also promised that health warnings on cigarette packs would be enlarged.[342-346]

Mauhart spoke of this meeting (where the "presentations and discussions went as expected"[340] and which thus was a success from the viewpoint of industry) of a confrontation of "speculations and real scientific results", recognising only those results as 'scientific' which were not disadvantageous for the tobacco industry. The industry (with the aid of these well-known experts) tried to prove that "all this would not be as bad" and at worst apply only to some individuals with a tobacco allergy or an impaired cardiovascular system. And, if a problem at all, for the majority of non-smokers smoking would be a minor issue. These tactics, spreading uncertainty about the harm of passive smoking, have been successful for a very long time. Non-smokers thus did not find an ally in Health Minister Löschnak.[342] A more detailed description of this hearing and the events around it can be found in Appendix S.

In 1990, Health Minister Harald Ettl (SPÖ) initiated the first youth campaign with the vacuous slogan "smoke off" *(Appendix O)*. At that time, 'negotiations' about health warnings on cigarette packs and bill boards were still underway with the then *Austria Tabakwerke* (following a proposal by Parliament in autumn 1989).[294] Ettl mildly criticised the tobacco company for their indirect, subtle advertising scheme, which appealed to unconscious needs of youths, being "good from a technical point of view but problematic for health policy". He even warned the

[e] "Controlled" in the sense that most if not all speakers were carefully chosen by the tobacco industry.

tobacco company 'with a raised forefinger' that, if negotiations with the company about its aggressive advertising strategy and the application of health warnings should be unsuccessful, the health commission of the National Council would deal with it and "might draw close to a total advertising ban", including indirect advertising, such as chocolate cigarettes under popular brand names.[347]

This, however, was certainly no threat for the tobacco industry, and not even a preparation for the 'shock' still to come.

In 1993, the Minister of Health, Sports and Consumer Protection, Michael Ausserwinkler (1992-1994, SPÖ), issued a draft tobacco act which ushered in a total ban on advertising to begin in 1996, along with severe penalties for the import of strong cigarettes. The draft law was subject to harsh criticism and was among the main reasons that led to the departure of the health minister in 1994.[270 277]

As reported in the telephone conversation with the former health minister in February 2004, reactions to these first drafts were quite extreme. They caused massive resistance particularly from parts of the coalition party ÖVP, in particular from the then Minister of Economics and now Federal Chancellor Wolfgang Schüssel, though not from the two ÖVP-spokesmen on health. However, even elements of his own party (SPÖ) were against this law. The strongly influenced workers' council of *Austria Tabak* was threatened with unemployment in the industry. The issue of an advertising ban was even discussed in the parliamentary committee, although eventually leading to agreement between the two coalition parties, SPÖ and ÖVP, to proceed. However, shortly afterwards, a proposal came from the conservative party that, to prove the effectiveness of cigarette advertising, an advertising psychologist had to be consulted. Ausserwinkler agreed, not knowing that the same expert had also designed the advertising strategy of *Austria Tabak*.[277]

Reactions even came from an obviously deeply troubled Germany. Volker Hauff, the then president of the *Deutscher Zeitungsherausgeberverband* (newspaper editors' association of Germany) and former German Minister of Sciences, whose relationship with the tobacco industry was later exposed by the magazine *Stern*[348], paid a personal visit to Ausserwinkler, threatening that, if the health minister succeeded in enforcing this law, he would have to face "strong adverse winds" from the international press.

Ausserwinkler also initiated a population-wide campaign *(Appendix O)*, primarily aimed at facilitating the passage of the tobacco act. Reactions to this campaign were equally strong. Beppo Mauhart, General Director of the Austrian tobacco company and President of the Austrian Football Union, felt personally offended. Michael Ausserwinkler, being Minister of Health, Sports and Consumer Protection, was threatened that football clubs would receive no more money from the tobacco company (the main sponsor) and the clubs were instructed accordingly. Being a most influential force in the parliamentary party (SPÖ), Mauhart also campaigned against Ausserwinkler within the party. In particular, the axis of Androsch and Mauhart, friends and former colleagues in the Finance Ministry *(see above)*, was most active in opposing the health minister's plans, resulting even in personal disparagements. In a written dedication in a biography about Beppo Mauhart on the occasion of the latter's 60th birthday[f], Hannes Androsch tried to portray Michael Ausserwinkler as a ridiculous figure.[277]

Given the willingness of the Austrian tobacco industry to spend 20 times as much on one cigarette campaign, these reactions to a small campaign, which was no competition to the massive campaigns of *Austria Tabak*, seem quite exaggerated, but obviously expose the tobacco industry's and their allies' fears of possible damaging effects and the threatening effects of even small and 'harmless' campaigns. One could assume, therefore, that the tobacco industry has been more aware of the effectiveness of anti-smoking campaigns than most public health politicians have ever been.

Equally vocal reactions followed the Health Minister's proposal for smoke-free environments in restaurants and cafés, a political issue raised for the first time in 1992 *(more on this see Appendix Q)*.

To cap it all, Michael Ausserwinkler also proposed allocating tobacco taxes to anti-smoking activities – the informally named *"Rauchermilliarde"*, indicating the approximately ATS 1 billion to be raised by the proposed extra charge of 50 Groschen (€0.04) on every pack of cigarettes. These funds should have been transferred to the Fund for a Healthy Austria to finance therapies and anti-smoking campaigns. However, due to strong opposition (economists argued that this measure would promote inflation), this initiative could not be realised.[277] Although tobacco taxes have been used for funding general health promotion activities for many years

[f] The title of this biography is: *Politik, Tabak und 60 Jahre* (Policy, Tobacco and 60 Years), edited by Hans Dibold, the known editor of various general and special gourmet guides *(Appendix Q)*, including, for example, the European Cigar Cult Journal ("The Journal for Fine Smoke & Savoir Vivre").

now, these funds have never been related specifically to any anti-smoking activities *(Chapter 8)*.

Finally, increased pressure led to the health minister's removal to Carinthia in March 1994. Only with EU accession in 1995, when action became necessary, a much weakened, minimal version of the original tobacco law was passed by Parliament.[277] The new law only included partial advertising restrictions and despite two amendments in 2001 and 2003, no major changes have been made *(Chapter 8)*.

After Michael Ausserwinkler, a long silence on tobacco policies followed, regardless of which of the three political parties held the health portfolio, with all dreading the political unpopularity and destiny. Health Minister Christa Krammer occasionally commissioned studies on the effects of passive smoking but apart from the brief and very low-budget repetition of Ausserwinkler's campaign in 1995 nothing happened.

The present Health Minister, Maria Rauch-Kallat (ÖVP), has transferred all smoking-related issues to the State Secretary of Health, Dr Reinhart Waneck (FPÖ).[g] Apart from the obligatory and well-known phrases expressing concerns about alarmingly high and rising smoking rates among Austrian youths and the necessity to tackle this problem by youth campaigns, no other measure has been proposed by the Health Minister. Presently, even the youth campaigns of the Ministry are more or less confined to the minimum expectations from EU-wide campaigns *(Appendix O)*. Particularly after the introduction of the Irish smoking ban, Austria's tolerant approach based on "voluntary agreements" has been emphasised by both the Health Minister and the State Secretary. The Health Minister occasionally announces that "steps will be taken", but as yet implementation is lacking. In a recent television discussion following the Irish smoking ban, the Health Minister emphasised that one has to proceed against smokers moderately, i.e. "with the right measure" *(Appendix V)*.

More recently, in particular following the discussion after the introduction of the Irish smoking ban, the Health Minister announced an intention to "rigorously fight" smoking in the workplace with existing laws to be enforced, and with pressure on the hospitality industry for voluntary agreements on more non-smoking areas. During the summer, she would like to develop a bill in co-operation with the Ministry of Economics *(sic)* to be presented in autumn 2004 before agreed upon in parliament.[349]

[g] Since July 2004, the State Secretariat for Health has been dissolved.

When occasionally citing the Health Minister for her "courageous" stepping up for the protection of non-smokers, the name of her "forgotten" predecessor, Michael Ausserwinkler, who had certainly tried with more commitment, has never been mentioned. Again, this follows an apparent scheme in Austria that whatever concerns tobacco policies is treated as something new or unique – and, as it is with new things in Austria, these should not be rushed.

The State Secretary, who is also president of the Fund for a Healthy Austria, is (or was[h]) in charge of all addictive drug-related issues. Although frequently making public statements on the health hazards of smoking, referring to the burden of disease and loss of years of life, he is strictly opposed to any kind of ban or restrictions in public places or to tax increases on cigarettes. Even in the field of public health, tobacco control measures which have been found to be effective elsewhere are seen as 'unnecessary' in Austria, where things are handled on a 'voluntarily' basis, being otherwise too 'authoritarian' and an undue interference into people's life. He (and his office) speak repeatedly of not wanting to "criminalise" smokers. Measures should not be "rushed" but taken step by step – and stopped again as soon as one could see an improvement *(sic)*, so people would no longer be patronised. Both he and the Health Minister emphasise that "strict laws" already exist and it would be enough if these were adhered to. Whether deliberately or unknowingly, both politicians have been using the phrase "it is not allowed to smoke publicly" in this connection, thus mixing up smoking in public buildings and public places. This mistake is repeated by the print media.

The worst thing, so Waneck argues, would be to be puritanical on this issue. There is a clear 'Yes' to curbing measures and making access more difficult, but no need to "throw the baby out with the bathwater". As with alcohol, everything should be done in moderation.

> *"If you do not smoke more than 3 cigarettes per day, you will never stand out as a smoker, also from a health point of view."*[288]

According to an interview with the State Secretary by the newspaper *der Standard*, the reason for his strict opposition to smoking bans in public places is the protection of youths: By pushing them out from the bars in the street one would bring them closer to drugs *(sic)*. He continues:

> *"Health also means not to drink alcohol and not to go to McDonald's... If we prohibit smoking in restaurants and bars, we would also have to prohibit alcohol because this is at least equally damaging... One can forbid nobody to be or to get ill."*[350]

[h] See Footnote g.

The principal problem facing any legal measures, so Waneck contends, would be the shared competences of various Federal Ministries (Economics and Labour, Finances, Health, Social Affairs, Education). Many decisions would also be the responsibility of the Länder.

In the meeting, when asked what, in theory, he would see as the main goals in an anti-smoking campaign, Waneck said that he would focus on two things: First, he would stop youths taking up smoking and second, he would try to make adults stop smoking before the age of 40. Anything else would not make any difference.[288] He summarised his (theoretical) approach to tobacco control measures in five points:

1. curbing consumption
2. added difficulties of access (as late as possible, i.e. not under 16)
3. stopping again all anti-smoking measures as soon as possible
4. maximal non-smokers' protection
5. and rigorous adherence to existing laws – thus no smoking in public environment (restaurants etc. are seen as private environment)

However, no definite answers could be given as to how to curb consumption, nor what would be a "maximal non-smokers' protection" without smoking bans in public places. It is also not clear what he really means with reduced access for youths as at the same time he opposes the removal of cigarette vending machines and stricter laws including sanctions. With regard to cigarette vending machines he proposes "let's first see what the Germans will accomplish" and with regard to youth smoking he shifts responsibility to the Minister of Education, Elisabeth Gehrer, who is strictly opposed to a total smoking ban in schools, for pupils and teachers alike.

Present EU policies are described by Waneck as a policy of prohibition. Apart from being too extreme, they certainly would not work, segregating a whole group of the population who cannot kick the habit of smoking. Later on in this discussion, though, he defended Austria when criticised for being so demonstratively reluctant in the implementation of effective tobacco policies by pointing to the "active role" Austria played in international discussions that led to the Warsaw Declaration and the FCTC which, of course, were also signed by Austria. This peculiar Austrian attitude with regard to unpleasant political questions was already discussed earlier.

The reason cited as to why nothing has been done on a population level to reduce smoking is that this would require great effort and expenses, the latter being not available. Besides, it would "not make much sense to initiate a campaign when the structure for sustainability is missing".[288] In view of the very brief youth campaigns, which neither show sustainability nor

are they embedded in any kind of 'structure', this claim lacks consistency. More notes from this meeting can be found in Appendix T.

Taking all these points together, the discussion in Austria on tobacco policies can be summarised under the heading "Liberty versus Addiction" (as was indeed the title of the Ministry's Health Dialogue on Smoking of 27 February 2004). Besides, Austria's approach is characterised by a "policy of small steps", combined with a general lack of political will, and the dogged defence of voluntary agreements and youth campaigns as the most promising measures to tackle smoking and health hazards.

Other Ministries

Other ministries involved in anti-smoking measures have been the Ministry of Education (another ministry that changed names frequently, presently the Federal Ministry for Education, Science and Culture), the Ministry for Labour and Economics (presently combined in the Federal Ministry for Economic Affairs and Labour), the Ministry of Finance, and the Ministry of Sports (until 1 May 2004 Federal Ministry for Sports and Public Services; since then only State Secretariat for Sports while the Federal Chancellor, Wolfgang Schüssel, is also Minister of Sports).

The Ministry of Education has been co-operating in youth campaigns held in schools. Presently the Ministry supports the campaign "Smoke-free School". Erhard Busek, Minister of Education in 1995 and Vice Chancellor from 1991-1995 (ÖVP), was responsible for introducing a total smoking ban in schools and the removal of smoking rooms for pupils. This total smoking ban did not last long; Elisabeth Gehrer (ÖVP), Minister of Education since 1995 and former primary school teacher, was, and still is, opposed to a general smoking ban in schools.

The Ministry for Economic Affairs and Labour is responsible for the Employees' Protection Act, which excludes employees of the hospitality industry and all other establishments where customers are allowed to smoke. One relevant factor is that this ministry presently also represents the interests of the economy and industry, although when enacted it was a separate ministry hold by the Social Democratic Party.

A chief player is, of course, the Ministry of Finance with its economic interest in both high tax revenues from tobacco consumption and its stock ownership of the Tobacco Monopoly Administration (distribution of tobacco products). In the past, when *Austria Tabak* was still state-

owned and under the responsibility of the Finance Ministry, there were also financial interests in the fortunes of the company.

The Sports Ministry has been important with regard to sports sponsorship, in particular sponsorship of football clubs and football matches, but also sponsorship of the Austrian ski team and other sports events by *Austria Tabak.*

9.3.3 National institutes, researchers, addiction specialists

Although not key actors in tobacco policies in the narrow sense, some of the actors mentioned below are important side-players, occupying key positions and being closely related to key players. They are best characterised as key 'non-actors' or even key blockers, and therefore contributing decisively to Austria's stagnation in tobacco policies by simply refraining from action, blocking effective measures, or contributing to the 'controversy' about certain issues, such as passive smoking.

The following institutes, research departments and individual scientists are involved with smoking, either by initiating campaigns, providing information on smoking habits, offering help for nicotine addicts, or doing research in smoking-related diseases.

Smoking behaviour (university institutes):

- Institute for Social Medicine of the Medical University of Vienna (headed by Michael Kunze) with its adjacent Nicotine Institute (headed by son-in-law Ernest Groman), which promote themselves as the main contact for all tobacco-related issues, in particular cessation. Tobacco industry funded studies *(see later).*
- Institute for Environmental Hygiene of the Medical University of Vienna, department for prevention (headed by Manfred Neuberger), which provides a website with information on tobacco-related issues and does some smaller studies on smoking in the workplace.
- Ludwig Boltzmann Institute for Medical and Health Sociology, which has been involved in the WHO's HBSC-study. It also initiated the Austrian youth campaign "Smoke-Free School" (key person Wolfgang Dür).
- Ludwig Boltzmann Institute for Addiction Research, studying smoking behaviour.
- Institute for Social Medicine of the University of Graz, studying smoking behaviour.

Epidemiological research in tobacco-related disease and cessation (university and hospital departments, individual scientists):

- University of Vienna, Institute for Cancer Research, Department for Epidemiology (headed by Christian Vutuc, cancer epidemiologist, publishing on lung-cancer incidence and mortality, tobacco industry-funded studies on health effects of light cigarettes in cooperation with Michael Kunze).
- Lainz Hospital (City of Vienna), department for pulmonary diseases (headed by Hartmut Zwick, also head of the 'Medical Fitness Team'; research on chronic obstructive pulmonary disease and support for hospitalised nicotine addicts).
- Otto-Wagner hospital, department for pulmonary diseases (key person Wolfgang Kössler, study on smoking cessation).

Finally, the National Fund for a Healthy Austria is the institutionalised conscience of the government for all kinds of health promotion activities. Although funded exclusively by tobacco taxes, the Fund's activities in anti-smoking campaigns are very modest and more or less confined to its role as the national partner in EU campaigns. So far, it has no impact on smoking rates among youths.

As indicated, some of these actors play a greater role in Austrian tobacco policies than it would seem at first. Some of the names mentioned above are Austria's leading anti-smoking advocates, heading Austrian anti-smoking associations *(see following section)*.

One name, however, that turns up immediately whenever the issue of smoking, smoking cessation, and tobacco control is raised, is Michael Kunze, professor of "public health", head of the Vienna Institute for Social Medicine, long-time expert in tobacco control, national counterpart for WHO and EU institutions for tobacco control, and former government consultant to some SPÖ Health Ministers. Politically very astute and well connected to top members of the Social Democratic Party, this institute was established for him in 1983. He has been known for a long time for his advocacy of pharmaceutical products for smoking cessation. Recently he has also become known for another controversial substitute. Together with Ernest Groman, head of the adjacent small Nicotine Institute and his son-in-law, and the Swedish scientist Karl Fagerström, he is pushing for the legalisation of smoke-less tobacco (snuff), ostensibly as an alternative to cigarettes for heavy smokers.

The activities of these two institutes[i], though, might be characterised by ambiguity and ineffectiveness. Passing more or less unnoticed, they have been organizing the National Awareness Day on 1 January (a perhaps surprising choice). The Nicotine Institute shows remarkable concern for heavy smokers, in particular all those where "complete abstinence is not possible" by

[i] With Michael Kunze being the key figure and loyal employees working on the "front".

offering possibilities for "controlled smoking" (long-term and high-dosage NRT treatment) and pleading for the legalisation of moist snuff *(snus)* in Europe[69 351]. It also uses the results of one of its own small surveys to "argue" for campaigns to reduce smoking rather than to quit smoking (neither of which exist anyway). Although claiming to be a "competence centre" and the 'first address' to be contacted for smoking cessation, the Nicotine Institute neither offers a help-line nor cessation courses. The reasons have been reported to be lack of funding by both government and health insurance funds, as well as "failure" in the past. However, both institutes developed the concept for the *Josefhof* in Graz, copied by similar centres supported by the Upper Austria District Health Fund and the insurance fund for civil servants, and the outpatient treatment centres supported by the Lower Austria District Health Fund. In Vienna, occasional meetings are held about twice a year to inform smokers seeking help who have the patience to wait for this event *(Chapter 8; 8.3.5)*.

Otherwise, the Nicotine Institute (or rather, its head) distinguishes itself by an uncritical attitude towards smoker-friendly media reports, considering them better than no reports at all[191], drawing attention to industry-funded studies (as, for example, the study by Enstrom & Kabat[107]) or to its own studies suggesting the merits of smokeless tobacco[67 68] *(Section 9.3.8)*, regarding the effects of passive smoking as still being controversial, categorising help-lines as being quite useless, and describing discussions about industry tactics as exaggerated.[191]

Michael Kunze, the self-proclaimed Austrian "Non-Smokers' Pope", who advertises himself as the "most dangerous man for the tobacco industry", has always been closely related to the Austrian tobacco industry, personally and, as we shall see, also financially. He was a school friend of Dr Hubert Klus, the previous head chemist of *Austria Tabak* (now retired but still acting as company consultant), and has maintained a "good communication basis" to *Austria Tabak*[331] (following the Austrian tradition of having a relaxed relationship between all parties). However, while his relationship with the tobacco industry has only been suspected by some, his association with the pharmaceutical industry was openly acknowledged[352].

Considering his involvement in tobacco control for decades and his almost equally long participation in international committees as Austria's national representative[j], his achievements in Austria so far have not been especially impressive. Although it is true that Kunze had a renowned consultancy status with various Austrian SPÖ Health Ministers (starting with his 'pa-

troness' Ingrid Leodolter and including at least the Health Ministers Herbert Salcher, Franz Löschnak, and Michael Ausserwinkler, possibly also others), there is also information about his close relationship to the Austrian and German tobacco industry which financed at least some of his studies *(Appendix U)*. Thus playing successfully a double role for decades, with his "balanced" or "controlled" expertise, his (and members of his institutes) occupying relevant positions and blocking effectively "undesired" measures, he has been an important though untransparent key player. However, due to the very limited space available, the full discussion of his activities is in Appendix U.

9.3.4 Anti-smoking groups and non-smokers rights associations

Those favouring restrictions on smoking are not well or even at all organised in Austria. There is no strong non-smokers' organisation. Basically one can say that there has not been much action in Austria – either because of corruption and deliberate blocking, lack of political and public support, or weakness and anxiousness of possible personal disadvantages.

The most active and certainly most committed organisation is the *Österreichische Schutzgemeinschaft für Nichtraucher* (Austrian Association for the Protection of Non-Smokers), active since 1975 and officially founded as an association in 1987. In earlier years, this association had branches in Vienna, Salzburg, Bregenz (Vorarlberg) and Graz (Styria). However, due to the lack of interest and the advanced age of its members, these branches have literally become extinct (no successors) and the only 'survivor' is its founder and head Robert Rockenbauer in Innsbruck (Tyrol). At its latest annual meeting in January 2004, only 8 participants turned up.

Since 21 June 1975, the *Schutzgemeinschaft* has been publishing a quarterly journal and since 1988 it has been initiating and conducting anti-smoking campaigns, in particular posters, stickers, leaflets and other information material. In addition, Robert Rockenbauer has been giving (for free) educational talks at schools for many years. He is the contact point for journalists seeking information on smoking-related issues and (despite the profile of another self-proclaimed 'advocate') generally known among insiders as "the" expert and real non-smokers' advocate in Austria. The association has been demanding an amendment of the tobacco law for

[j] Both Kunze and Groman have been members of the EU Regulatory Committee on Tobacco and the EU Expert Tobacco Working Group and participated in the process of developing the FCTC as members of the Austrian delegation. Kunze was also a member of the International Union against Cancer (UICC) *(present status not confirmed). (See also further down this section.)*

a long time, in particular the inclusion of measures to protect non-smokers in public places and penalties for violations.[k]

Despite its activities the association receives virtually no public funding; nor does the government pay any tribute to its achievements. Reasons may include party-political issues, the physical distance between Vienna and Innsbruck and the attitude of Vienna towards activities in the provinces, which very often are not taken seriously. The government prefers to maintain direct control over the entire health promotion budget through the Fund for a Healthy Austria, despite its limited success with regard to smoking prevention activities.

Robert Rockenbauer, being a notable exception within the otherwise rather diffident and very cautious group of Austrian non-smokers' advocates, may be described as a very dynamic, altruistic, self-confident, unafraid and dedicated individual from Tyrol, a region known for the bravery of its freedom fighters. Uniquely in Austria he has taken on the tobacco industry in court.[l] He was also the only anti-smoking advocate who readily agreed to a meeting, which ultimately lasted almost four hours. Of the other three anti-smoking advocates, all members of the Austrian Council on Smoking and Health, no one found time for a discussion, not even by telephone, despite several attempts. The arguments varied from mostly "no time" and "too busy", to "can't say very much, the situation is far too complicated", or just answering 'harmless' questions and missing the point, while referring to websites and (often irrelevant) publications. One could also sense a fear of investigation.

The contacted individuals were:

- Manfred Neuberger, long-time expert and anti-smoking advocate, studies on smoking in the workplace, former government consultant (SPÖ), past president and now vice-president of the anti-smoking association Austrian Council on Smoking and Health and provider of its website.

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[k] In 1980, the *Schutzgemeinschaft* initiated also the 'Year of Non-Smoking', an idea which, according to Rockenbauer, was taken up by the WHO, putting the 1980 World Health Day (31 March) under the motto "Smoking or Health – Your Choice".[303]

[l] On 22 November 1988, Robert Rockenbauer was sued by the tobacco industry for millions of Austrian Schillings for defaming the advertising of Camel cigarettes (the so-called 'Camel Process'). Instead of the original slogan 'I am walking miles for a Camel' he produced a poster saying 'Only a camel would walk miles for a cigarette'. His position was upheld in the Higher Regional Court in Innsbruck but was challenged again and the case went to the High Court of Justice in Vienna where damages were awarded against him of ATS 150,000 (€11,000) for honour defamation as 'camel' may suggest a person who is not very intelligent.[303] Interestingly, in Vienna this case was decided by a senate for economic affairs, who had connections to the Austrian tobacco company and its General Director (then deputy) Beppo Mauhart.[334] Far from being intimidated or awed, though, he continued to produce this poster in variations (e.g. 'only a ... [dot-dot-dot] ... walks miles for a cigarette' or 'not even a donkey would walk miles for a cigarette').

- Kurt Aigner, medical expert and president of the Austrian Council on Smoking and Health.
- Michael Kunze, vice-president of the Austrian Council on Smoking and Health *(see above)*.

Both, Manfred Neuberger and Michael Kunze, were government consultants to some SPÖ Health Ministers in the past and thus influenced Austrian tobacco policies to some degree.

9.3.5 Health insurance

Almost one fifth of Austria's health care expenditure is spent on the treatment of smoking-related diseases. In fact, Austria's health insurance should be one of the major interest groups in supporting measures to reduce smoking. However, the Federation of Austrian Social Insurance Institutions has neither been providing support for smoking cessation, nor has it initiated or supported anti-smoking campaigns. It has no staff specialising in smoking-related diseases. Repeatedly, health politicians have given the misleading impression that the *Josefhof* is a project of the Federation.

The Vienna District Health Fund employs one person to be in charge of its very few information centres on cessation. It sends severely ill nicotine addicts for a three-week treatment to the *Josefhof* in Graz but, as noted earlier, the possible yearly quota of 100 patients has not yet been achieved. The Lower Austria District Health Fund supports four ambulatory treatment centres and the Upper Austria District Health Fund offers three in-patient cessation centres based on the concept of the *Josefhof (Chapter 8)*.

In summary, therefore, the Austrian health insurance does not play a role in Austria's tobacco control policies (apart from receiving money from tobacco taxes to reduce its deficit).

9.3.6 Other non-governmental organisations

Among the non-governmental organisations only the Austrian Cancer Society, which initiated a youth anti-smoking campaign, and the regional *Arbeitskreis für Vorsorge und Sozialmedizin (AKS)* in Bregenz/Vorarlberg, whose health promotion activities in education and smoking cessation are outstanding within Austria, can be identified as playing an active role in tobacco control. However, they have no influence on decision making on tobacco control. The Austrian Medical Chamber does not play any role.

9.3.7 Local governments

Local governments and health authorities do not play a role in tobacco control policies. The City of Vienna's only information centre for smoking cessation is highly unprofessional *(Chapter 8)*. In response to a question from a journalist asking whether Vienna could do anything at a regional level to ban smoking in public places (following media reports on the Irish smoking ban), the then City Councillor for Health in Vienna, Elisabeth Pittermann, said this would be "impossible" and could only be dealt with on the national level. (National health politicians, on the other hand, cite the autonomy of the Länder as a reason for inaction.) Although a declared non-smoker and one who states she is annoyed by tobacco smoke, she has been emphasising repeatedly her aversion to smoking bans, thus reflecting the wide-spread opinion among policy makers.

9.3.8 Media

The media, as one of the most important opinion leaders, play a crucial role in the creation, dissemination, and consolidation of public opinion and attitudes. On the issue of smoking, Austrian media coverage has been somewhat one-sided, contributing to the smoker-friendly climate in Austria. One important reason has been the excellent relationship between the media and the Austrian tobacco industry, in particular during the reign of Beppo Mauhart *(see above)*. Another reason is perhaps the fact that most journalists are (often heavy) smokers themselves.[353]

Given the diverse nature of this coverage it was not possible to be systematic. Instead, selected Austrian media reports, in particular following the recent implementation of enlarged health warnings on cigarette packs and the introduction of the Irish smoking ban in public places, which briefly aroused the interest of the otherwise disengaged tobacco-landscape within the media, were placed under greater scrutiny and analysed. Media reports on the use of tobacco taxes have already been presented *(Chapter 8)*. It was not possible to arrange discussions with a TV journalist and one from an Austrian news magazine. The results of this media analysis are presented by topic.

The two TV discussions, one following the introduction of health warnings and another following the introduction of the Irish smoking ban in all workplaces, were particularly interesting as they reflected public opinion and showed who the real opinion leaders were. Both discussions were dominated by the personality (and speaking time) of the retired Ex-General Director of *Austria Tabak*, Beppo Mauhart. His frequent presence as the representative of smokers (and,

unspoken, as the representative of the tobacco industry) is seen as contributing to a "balanced" debate.

General characteristics of smoking-related media reports

In general, media reports on tobacco control measures are introduced by a paragraph or two on lung cancer rates, the alarmingly high or rising smoking rates among Austrian teenagers and women, and/or statistics on cigarette consumption. They are often supplemented by at least one picture of smoking individuals and indirect advertising.

Very often, the language chosen to describe non-smokers or anti-smoking measures uses a very combative vocabulary, while smoking is presented as a matter of personal choice and great pleasure, enjoyed by sociable, emancipated and self-determined individuals. The terms used in the media reports analysed can be summed up as follows:

Box 9-1 Terms used in media reports to describe smokers/smoking and non-smokers

Smokers and smoking	Non-smokers and anti-smoking measures
liberal, free, self-determined; right for pleasure (of smoking)	fascistic, protofascist, authoritarian, totalitarian, patronising, intolerant, militant, exaggerated; discrimination of smokers
pleasure of smoking; to smoke with pleasure/ gusto; to enjoy/relish smoking; tobacco pleasure	pleasure-hostile
"sexy smoke", association with movie stars (Humphrey Bogart, etc.)	puritanical
century-long smoking culture (with the attached pleasure); originally therapeutic means of tobacco; sacral function	bait, crusade against smokers; pursue of smokers; criminalisation of smokers; social exclusion of smokers; battle, battlefield between smokers and non-smokers
examples of famous smokers in history (politicians, writers, movie stars, etc.)	most famous non-smoker: Adolf Hitler

Most media reports are defiant against the "militant" anti-smoking campaign of the EU with its "fascistic" and "pleasure-hostile" approach. The overall tone is that the dangers of smoking (especially passive smoking) are exaggerated, thus discounting the rights of non-smokers. The issue of smoking and measures to reduce smoking is considered most controversial, a confrontation of "liberalism against prohibition"[354], a battle between (suddenly having become) intolerant non-smokers who want to interfere with a smoker's pleasure against discriminated, criminalised smokers who only claim their right for a 'little pleasure'. Articles in favour of tobacco control measures are often "balanced" by smoker-friendly articles on the same page[355] and arti-

cles presenting alarming results on environmental tobacco smoke or high smoking rates in Austria are "balanced" by pointing at length to the ineffectiveness of tobacco control measures *(Appendix V)*. In addition, some of the few reports on smoking are based on industry-friendly information provided by Austrian scientists and so-called anti-smoking advocates, as recent examples show.[67] [68] Furthermore, articles trying to appear 'objective' in their reporting on tobacco control measures, in particular on smoking bans, and thus to present 'all sides', usually cite the expert opinion of a so-called anti-smoking advocate who has been known to be very closely related to the tobacco industry. However, despite this clear under-representation of those favouring restrictive measures and the more than cautious or even vacuous statements of this Austrian expert, it is interesting that many people have indeed the impression of facing a new development where 'discussion' on these issues starts.[356] Austrians have never faced vehement statements from opinion leaders, including the exposure of the tobacco industry and revealing the real harms of active and passive smoking. Still in 2004, occasional statements regarding the harmfulness of "light" cigarettes[128] [357] are treated as something "new" in the Austrian media (and perceived as something new by large parts of the public[356]. Still, a most recent article in the *Kronen Zeitung*, Austria's most widely-read tabloid, reported critically on the harmfulness of "light" cigarettes and some smoking-related issues, citing not Michael Kunze but the German expert Dr Martina Pötschke-Langer from the Cancer Research Centre in Heidelberg.[357] The *Kronen Zeitung*, to give it credit, also offers a website with information for smokers seeking to quit.[358]

The cover story of the news magazine *Profil* of 24 November 2003[265], which claimed to present this controversy "objectively", never spoke just of smoking, but always in terms such as the "pleasure of smoking". The term "addiction", though, was hardly used. Smoking was "delicious and wonderful", although it may also be dangerous. The dangers of passive smoking, it argued, were exaggerated; it was only considered that children and pregnant women were adversely affected.[m] A list of "famous smokers" in history was presented, as well as much indirect advertisement: almost every one of the numerous photos pictured a smoker, a cigarette butt, a cigarette pack (Marlboro), or a celebrity with a cigarette or a cigar. Critics were cited alluding to a relapse to "past times". The stealthy "prohibition" of the "free smoking culture" would be characterised by austerity and puritanism *(Lustfeindlichkeit)* as in periods of suppression, evoking a "protofascist approach" behind this EU "anti-smoking-military campaign". In summary, the report (incidentally written by a heavy smoker) is clearly dominated by compassion for smok-

[m] These arguments were based on the results of the industry-funded study by Enstrom & Kabat[107], which was provided to the journalist by Ernest Groman from the Nicotine Institute.

ers, who would now be criminalised and discriminated, accompanied by justification for smoking, while mocking tobacco control measures.

The very few articles on passive smoking are usually short and presented as something "new"[128] while studies on the benefits of smoking on mind and emotion[359] or the merits of smoke-less tobacco[67 68] are presented at great length.

In December 2002, on the occasion of the discussion of the EU advertising directive, the Austrian newspaper *der Standard* reported on "the individual's responsibility for itself". Smoking bans in public places, as in the United States, would be a "massive interference in the individual's freedom". Even if an advertising ban was independent of a smoking ban, the risk was summarised as "Where will it all end? After all, riding a motorbike, drinking Coca Cola and eating meat may be dangerous for the individual and for the society."[293]

Two recent events which evoked some media discussion, the introduction of larger health warnings on cigarette packs in Austria in October 2003 and the introduction of the smoking ban in Ireland, were analysed in more detail. The two television discussions[37 38], which covered various tobacco control measures, were analysed separately. These more specific analyses are presented in Appendix V.

Altogether, analysing the Austrian media landscape on the issue of smoking, one is reminded of the concepts towards the media developed in 1975 by the German *Verband der Cigarettenindustrie* which realised that it had to become "more active" in the discussion about smoking and health *(bolding by E.B.)*:

> "One must make sure that articles discharging the cigarette are made available to magazines and daily press. ... for this, **a liaison between the 'Verband' and journalists is necessary**. ...
>
> "It is suggested to hire a photograph agency specialised in **press pictures showing well known personalities smoking publicly**.
>
> "It must be tried to launch press articles in which the **anti-smoking measures, resp. the intolerance of the smoking opponents are mocked in a sympathetic way**."[100]

It seems that in Austria, Beppo Mauhart has not only made a most successful job out of this proposed strategy; it also demonstrates that, even under slightly changed conditions and supported by unambiguous statements of opinion leaders, public opinion (and thus also the opinion of journalists) will take some time to change.

9.3.9 Public

Public opinion and public awareness closely reflect media coverage. Discussions with citizens of different countries on the issue of smoking in public reveal the effectiveness of opinion leaders in constructing public opinion and awareness. In Austria, these opinion leaders are mostly industry-friendly and consist primarily of high-ranking representatives of the tobacco industry, scientists, and the media – the latter, however, may also be seen as part of the public, i.e. reflecting public opinion. The public, therefore, is both evidence of successful socialisation (in either way, pro- or anti-smoking) and an actor in the sense of influencing political decision making in several ways. Firstly, "expert opinions" of politicians and journalists are very often individual opinions; secondly, health politicians, in general, do not want to become unpopular; and thirdly, public with little awareness will not support anti-smoking groups and thus will not interfere with the established pro-smoking policy.

In Austria, public awareness on smoking-related issues is very low and discussions are clearly dominated by the magic word "tolerance". Appendix W illustrates the climate in Austria.

9.4 Policy Analysis

Austria has often been praised as a land of harmony, dreading confrontation but rejoicing in cordiality, joviality and agreeability ("one can talk about everything"); a land of proportion (everything is just a problem of moderation and a little bit of consideration; sanctions are not even discussed) where nothing is exaggerated or rushed ("let's see first what Germany is doing"; "we need to proceed step by step"; "one does not have to throw out the baby with the bath water"); a land of selective tolerance (in particular towards its own weaknesses) and of distorted self-perception ("we are one of the most active in European tobacco control" versus "this is all far too extreme and exaggerated"); and, most of all, a land of 'old pals' and 'buddies', best described with the well known and often applicable Austrian term *'Freunderlwirtschaft'* (cronyism). On the tobacco stage, the atmosphere is characterised by mutual understanding, tolerance, and a 'good communication basis' among all interested parties. Already in a confidential Philip Morris 1979 report on the situation in Austria one can read that the Austrian tobacco company "has good access to all of the media, prominent scientists and MDs *[medical doctors]* and members of government and parliament"[104]. Before privatisation of *Austria Tabak*, the relationship between the company and the government was also characterised by strong party-political ties.

Despite publicity about these close relationships, the reactions of key informants who either declined meetings or evaded answers were interesting. It proved exceedingly difficult to get people to talk about this subject. While most of the key informants answered 'harmless' questions relatively freely, such as on tobacco-related tax income and smoke-free environments in public transport, or provided material on laws, statistical data on smoking rates, etc., responses from many in the field of Austrian tobacco policy[n] were very difficult to elicit when it came to questions relating to tobacco policy. In particular when seeming to probe about why so little was done or indicating an interest in the relationships between *Austria Tabak* and those involved in Austrian tobacco policies, the reactions were usually evasive, even anxious, often declining to answer. Most notably, repeated attempts to obtain the opinion of acknowledged advocates in Austrian anti-smoking policy, some of whom have been long-term consultants to the government and being official national representatives in the international field, were unsuccessful due to their 'absolute lack of time' for a meeting or even discussions by telephone.

It may also seem one of the ironies that it is repeatedly reported by health politicians, governmental officials and the media that "despite" numerous anti-smoking campaigns over the last years, cigarette consumption has hardly decreased[349], thus being used as an argument that campaigns do not work anyway.[o]

Taken together, Austria's approach to tobacco control may be summarised as non-committal and hypocritical, as also described by Constance Nathanson for France[141]. While expressing concern about the alarmingly high and still increasing smoking rates among Austrian children and adolescents, one can observe an extraordinary ambivalence and high level of hypocrisy on the part of the Austrian authorities toward any restrictive measures that might be effective. For example, while forbidding the purchase of tobacco products by young people under 16 years, thousands of cigarette vending machines are operating in Austria and no sanctions exist for selling cigarettes to minors. Even smaller children can get their cigarettes whenever and wherever they want. They are also strictly opposed to complete smoking bans in schools (although an Austrian study certifies that schools above all are the places where youths are becoming "habitual smokers"[360]) and smoking bans in bars, pubs, cafés or restaurants where young people also 'learn' to smoke, trying to appear equally 'adult' as those around them. Any kind of restric-

[n] In particular officials and administrators in the Ministry of Health, external experts and government consultants, and even individuals engaged in anti-smoking activities and self-proclaimed advocates.

[o] As noted, the last anti-smoking campaign targeted at the whole population was in 1994/95 – following 14 or, when incorporating the small repetition campaign in 1985, nine years after the first (and in fact only) real population wide media anti-smoking campaign *(Chapter 8; Appendix O)*.

tions are countered with arguments such as "that will not work anyway", or "this is not a solution", or "one cannot forbid everything", or "they would only do it secretly and smoke even more because then it just becomes more interesting". At the same time, politicians do not tire of lamenting about the high youth smoking prevalence and expressing their determination to tackle this problem with yet another (more or less unsuccessful) youth campaign.

On the whole, the attitude of smokers in Austria may be described as cultivated inconsiderateness and ignorance. Non-smokers are either portrayed as "victims" (e.g. children and pregnant women) or, when protesting against another's smoke, as intolerant, pleasure-hostile trouble-seekers who just want to interfere with another's 'small pleasure'. As cited by Constance Nathanson in relation to France:

> " 'The smoker ... does not for a moment believe that the non-smoker is truly bothered. No, he simply wants to annoy, to deprive the smoker of a little pleasure'... This construction of smoking as *un petit plaisir* with which it is simply churlish to interfere largely explains why smoking restrictions are more readily respected aboard buses, trains, and airplanes than in cafés and restaurants. The latter are defined as zones of pleasure, whereas the former are not. ...
>
> "Images of the smoker out in the cold, of 'civil war between smokers and non-smokers' are invoked to argue against any overzealous enforcement of restrictions on when and where smoking will be allowed."[141]

It should be noted, though, that, especially after some discussion, some of the key actors (Austrian Federal Railways and Hospitality Trade Association) who contributed to this information gathering would be prepared to do something but expressed some uncertainty about the chances of success. In addition, it became clear that smoking bans would only be introduced if they were part of a wider net of measures, suggesting action should first come from policymakers on both the national and regional level.

So far, measures in northern Europe and Italy have been essentially ignored in Austria. Only the extensive international media coverage of the Irish smoking ban in March 2004 made Austria pay attention for an instant before reinstating the veil of silence over this whole unpleasant issue. It is to be expected that, should effective measures be introduced by Austria in the future, these will only follow international pressure or very strong economic interests.

Passive smoking has thus not been a topic of public discussion in Austria, nor of serious public health concern for politicians, nor of great scientific interest. Only very recently estimates were published by the Institute of Social Medicine on the mortality due to passive smoking in Austria.

Role of tobacco industry

The Austrian tobacco industry has been playing an important role in both the government's activities and the Austrian media. At least during the time when *Austria Tabak* was state-owned, representatives of the company were always involved in preliminary talks on tax issues, reportedly also in the planning stage of campaigns. For the media, particularly under Beppo Mauhart's reign since the late 1980s, the tobacco industry has been a very important advertiser and client, and Austrian media have carried much indirect advertisement. Finally, *Austria Tabak* has also had a very high expenditure on advertising, smoking campaigns and sports sponsorship. All these factors have made it difficult for smoking adversaries to be heard in the media. Considering later developments, the early media co-operation in Austria's first anti-smoking campaign in 1980 must be seen as an exceptional success.

While *Austria Tabak's* privatisation brought a certain disentanglement of the Austrian tobacco industry from the Austrian government, the former General Director of *Austria Tabak*, Beppo Mauhart, is still treated as THE expert in smoking-related issues (including anti-smoking measures) by the media. To get an idea about the relationship between *Austria Tabak* and Austria's government, one has to bear in mind that Beppo Mauhart was previously employed at the Finance Ministry as secretary of the then Finance Minister Hannes Androsch with whom (as with former Finance Minister and later Federal Chancellor, Franz Vranitzky) he has been close friends. He has always maintained a strong party political position and has been known as an "excellent lobbyist".[277] [297] [305] The role of *Austria Tabak* in sports sponsorship was facilitated by Mauhart being at the same time president of the Austrian Football Association, making *Austria Tabak* the main sponsor for sports clubs (in particular football clubs) and sports events; the company is also sponsoring the Austrian ski team.

In 1980, *Austria Tabak*, with the support of its representative in government, Finance Minister Hannes Androsch, could "strongly defend its position in a National Assembly resolution"[105] to reject Health Minister Salcher's package of tobacco control measures including advertising ban and health warnings. Another example of the tobacco industry's power is the rejection of the proposed comprehensive advertising ban under Health Minister Ausserwinkler, this time with the help of government opponents (ÖVP).[p]

[p] Government opponents (ÖVP) had invited an expert in advertising psychology to consider whether cigarette advertising would indeed *(sic)* tempt individuals to start smoking. The expert could find no proof and this argument was used to reject the advertising ban. Incidentally, this expert had previously designed *Austria Tabak's* advertising strategy.

The company which for decades has been commissioned by the government with surveillance of tobacco (in particular cigarette) constituents, *ÖKOLAB*, is a subsidiary company of *Austria Tabak*. Politicians seemed mildly surprised that this should indeed be so but were otherwise unconcerned.

Finally, as in most other countries, Austria's hospitality industry has been successfully influenced by the industry, with misleading stories about the adverse consequences for business of smoking bans, providing them with a means to argue that the government must avert this economic catastrophe.

Role of government

In addition to the general opposition to tobacco control measures by all three major political parties (SPÖ, ÖVP, FPÖ)[q] and in particular the close party-political ties between *Austria Tabak* and the SPÖ, the two most vehement opponents of tobacco control measures were (or are) oriented to economic issues: One was Victor Klima (SPÖ), Minister of Economy (1992-1996), then Minister of Finance (1996-1997), and finally, after Chancellor Franz Vranitzky's resignation, Federal Chancellor of Austria and party chairman of the Social Democratic Party of Austria (1997-2000). Under his chancellorship, an order was issued to restrain from excessive engagement in international tobacco control activities and to oppose the subsequently annulled EU advertising directive.[277] Klima was himself also a heavy smoker.

> "Klima used to be a heavy smoker and was probably one of the last politicians who smoked in public. During his premiership he was even hospitalized due to a nicotine-related illness."[362]

The other was and is, though not as openly as in the past, Wolfgang Schüssel (ÖVP), at that time Minister of Economy (1989–1995) and then Vice-Chancellor (1995–2000), who was the most vehement opponent of Health Minister Michael Ausserwinkler's proposal for the first tobacco act including a comprehensive advertising ban and his proposal of smoking bans in restaurants.[277] Presently (since February 2000), Schüssel is Federal Chancellor and also Minister of Sports. That a politician's smoking status is not necessarily an indicator of his or her attitude towards tobacco control measures, is best demonstrated with Wolfgang Schüssel. Being a non-smoker and a sports enthusiast, he is still, above all, economy-oriented, observing primarily the interests of the hospitality and the tobacco industry.

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[q] Although indicating within all drugs the legal drugs alcohol and nicotine as the greatest danger for the population, due to their wide prevalence, the party programme of Austria's Greens does not include any position on tobacco control.[361]

The reason why the company *Austria Tabak* has always been courted by the government were said to be mainly of economic nature, apart from political reasons (lobbying). Former Health Minister Salcher said that it has always been the interest of the government to represent the interest of lucrative or even profit increasing companies.[305] Neither Salcher nor Waneck nor other governmental informants saw anything "bad" with the tobacco industry, apparently completely unaware about its tactics.

Unlike in many other countries, as yet there has been no law suit against the tobacco industry in Austria. The legal situation in Austria would make this very difficult. According to the 1995 Tobacco Act (§3 [1]) the Health Ministry is authorised to decree an ordinance regarding additives of cigarettes (including additives for smell and taste, pesticides, etc.) "if it is necessary for the protection of the consumer from preventable health hazards". However, to date no such ordinance can be found. This means that additives are not regulated by any law.[280] In case of litigation this would mean that it would have to be the litigator who has to prove which substances pose a risk to health and that he or she has become ill due to the consumption of these cigarettes. Instead, if such an ordinance would exist, it would have to be the tobacco industry who has to prove that these substances are *not* harmful to the consumer's health.[363]

Attitudes by Austria's health politicians towards the FCTC and other declarations seem to be limited to a signature, showing 'officially' one's interest and obviously not wishing to appear a killjoy. 'Back home', however, they not only ignore all goals and commitments, but even declare them as 'ridiculous' and 'much too exaggerated' to be followed.

Another striking element in Austria's tobacco policy is the fact that policy makers are proud of things they are not responsible for, i.e. things not regulated in the tobacco act. For example, they repeatedly point out how well smoking bans in hospitals or local transport systems work – either to demonstrate the effectiveness of voluntary agreements, or to show that Austria has already done a lot ("What more can we do?"). They even proudly refer to Austria's (weak) tobacco law while nobody seems to remember the initial difficulties or the real reason for its implementation (EU entry) nor its comprehensive original version. Occasionally one even points complacently to the smoking bans at Austrian Airlines flights or Austrian airports – without mentioning the strong international pressure leading to it.

Similar to the earlier mentioned letter by the then Health Minister Herbert Haupt and his State Secretary of Health, Reinhart Waneck, to Gro Harlem Brundtland, where both health politicians declare their support for the FCTC, in particular referring to the desirability of a total advertis-

ing ban[279] [r], Austria's hypocrisy in this matter is again expressed in a reply of July 2003 from the Health Ministry to an anti-smoking advocate who reproaches the government for its inactivity:

> "On the level of the WHO and the EU there are framework conceptions and guidelines which support us very much in our efforts on the national level, as for example the action plans for a tobacco-free Europe or the... WHO Framework Convention for Tobacco Control, which has to be characterised as a mile stone in cross-country tobacco control and on whose development the Federal Ministry for Health and Women has also taken part... Important impulses are also to be expected by the... tobacco advertisement and sponsorship directive 2003/33/EC."[364]

In another, more recent letter by Reinhart Waneck of February 2004, answering a reproach to the Austrian government for its ineffective activities in tobacco prevention from an active member of the Austrian Association for the Protection of Non-Smokers *(Österreichische Schutzgemeinschaft für Nichtraucher)*, the position of Austria's policy towards smoking prevention is summed up quite clearly. Apart from the usual phrases regarding the Ministry's "regular campaigns", in particular targeted at youths, the self-congratulation for the exemplary tobacco law, and drawing attention to the fact that this would not only be the responsibility of the Health Ministry alone, it cautions against too "rigorous measures" such as smoking bans in restaurants, pubs and cafés as these would "endanger a violation of the individuality of the constitutional state".

> "...the existing frameworks and guidelines on WHO and EU level are a great support to us in the implementation of national measures regarding the protection of non-smokers. However, on no account one must overlook the fact that exactly these inter- and supranational instruments have been worked out by the various member states, thus also including Austria. Therefore, these are not measures ordered from outside, but it is the common will of all member states. This, however, should not and must not curtail the individuality of every single one. **Rigorous actions against smokers, as proposed by you, would be welcome to a certain extent from the viewpoint of health; however, ignorance of regulations regarding respective areas of authority, apart from constitutional problems, would in particular endanger a violation of the individuality of the Austrian constitutional state.**
>
> "The protection of non-smokers is a cross-sectional matter, i.e. the various aspects fall under the competence of the respective departments... such as the Federal Ministry for Social Security, Generations and Consumer Protection; the Federal Ministry for Education, Science and Culture; and the Federal Ministry for Economics and Labour; it also affects the responsibility of the Länder. Therefore, various acts such as the Employees' Protection Act and the various Youth Protection Laws of the Länder have encompassed regulations regarding the protection of non-smokers for a long time.
>
> "The smoking bans laid down in the Tobacco Act cover those areas which previously lacked regulation. **After carefully weighing the needs of passive smokers *(sic)* against the needs of smokers, the regulations in the Tobacco Act for the protection of non-smokers are primarily based on the thought to contribute to the harmonious living together of smokers and non-smokers.**[365] *[Bolding by E.B.]*

[r] See Footnote q in Chapter 8.

Of course, there is no discussion about asking the views of the population as to whether it is equally "harmonious" or if, as in Ireland and all other countries where a poll preceded these measures, the majority would approve of smoking bans.

Altogether, the predominant impression of Austria's policy makers in the field of tobacco control is their hope that the whole problem would solve itself – by consideration, tolerance, and voluntary action. Till then, however, one should proceed with moderation.

Role of the public health community

Austria's public health community is small; even fewer are the individuals engaged in tobacco control measures; and of these few, some are either close friends with representatives of the tobacco industry, therefore not wishing to hurt the other party, or are too anxious about their own position to go beyond small, cautious studies or come forward with clear statements regarding the need for action.

Public awareness and anti-smoking groups

In general, public awareness as to the harm of smoking and effects of environmental tobacco smoke is very low in Austria. Besides, Austrian people have a general aversion to direct intervention into something believed (or portrayed as) a completely 'private affair' and one of life's enjoyments. Therefore, any kind of suggestion as to smoking restrictions in public places, such as restaurants, pubs and bars, arouses arguments about not wishing to become "a second America" or being patronised by the European Union or being "criminalised" by a few "militant" non-smokers. Arguments regarding the high health care costs caused by smoking are either ignored or countered with arguments relating to other lifestyle factors, such as unhealthy food or air pollution, or set in the context of other, "much more dangerous and harmful" drugs, such as alcohol, hashish or other illegal drugs.

Despite the fact that the total of never-smokers, ex-smokers, children and adolescents, those who suffer from respiratory or heart disease, pregnant or breast-feeding women represent the far majority of the population, the need to protect non-smokers by establishing non-smoking environments in all public places is not recognised by the public (and policymakers). Those who feel annoyed or harassed by tobacco smoke have not been used to complain, with apparently little awareness of their rights.

Apart from the not very known Austrian Association for the Protection of Non-Smokers there is no strong non-smokers' rights association such as ASH in the United Kingdom. In view of the predominant pro-smoking climate in Austria and the open lack of political will, it would take an above-average amount of commitment and enthusiasm for activists to engage in anti-smoking activities.

9.5 Discussion

Smoking policy should be considered in a broad sense, aiming to reduce the burden of smoking-related diseases through different policy means such as regulation on access to tobacco and where it can be used, fiscal policy, and education.

According to differing estimates, smoking kills about 9,000 to 14,000 people each year in Austria, equivalent to 25 to 38 individuals per day. Recent estimates assume that in 2003, a total of 1,412 individuals died due to passive smoking. To date, Austria's health policy has done very little to reduce this death toll. There is no comprehensive tobacco control plan, nor even effective measures to curb tobacco consumption. Austrian politicians lament the high rates of cardiovascular diseases (especially heart diseases) and cancer, the high and still rising smoking prevalence among children and youths, and the high costs to the health care system, including the problems of present and future affordability. But two of the major factors underlying all this – smoking and alcohol – appear sacrosanct. The experience of countries that have introduced tobacco control measures, some of them for a prolonged period, shows that these measures are often followed by a significant decrease in smoking prevalence among both young people and adults and a decrease in smoking-related disease and mortality. However, this appears to have passed unnoticed in Austria – or rather, seems to be deliberately ignored. With its 'balanced' debate, drawing on the arguments of the industry, Austria's position remains stuck in the 1990s at best. In both past and present, Austrian pro-smoking policies can be summarised as pursuing narrow economic interests.

The very few and mostly ineffective measures have been directed towards youth campaigns and the praise of a small therapeutic clinic for severely ill smokers as a "model project for smoking prevention", thus keeping tobacco control off the political agenda. Again and again, politicians have expressed their concern about the high smoking rates among Austrian youths, occasionally followed by another study or by another (more or less unsuccessful) small-scale youth campaign. The high smoking rates among adults, the lack of any kind of support of or promotion for smoking cessation, the high health care costs of smoking-related diseases, and the high number

of smoking-related deaths have been of no concern for Austria's policymakers. Similarly, smoking bans in public places, such as restaurants, pubs and cafés, are still regarded as taboo and, demonstrating tolerance and liberty, are rejected in favour of voluntary agreements. Somehow there seems more unity in averting effective tobacco control measures than in promoting them. For decades, the strikingly smoker-friendly climate in Austria has thus remained unperturbed.

Lacking both public support and a non-smokers' rights group, the issue of non-smokers' rights has yet to reach the political agenda. However, even if it may take some time, the issue of passive smoking will pose a challenge for Austria's health policy. As with many other European countries, hope lies with the binding directives from the European Commission and the guidelines from the WHO. Apart from the importance of binding EU legislation, international pressure on Austria to introduce smoking bans and indirect pressure from more European countries, which have implemented effective tobacco control measures before Austria, will continue to be an important impetus to Austria's policymakers and the public to create a non-smoker-friendlier environment.

Strong opposition must be expected, however. Once the situation will become serious, it will invoke a major response on all sides (not only from the primary interest groups, i.e. the tobacco industry and hospitality industry, but also from politicians and the media) to convince the public of the ineffectiveness, ridiculousness and outrageousness of these measures, not missing the opportunity to compare it with the 'horrible' scene in the United States. By combining forces, Austrian decision makers in health policy, economics and social policy, in close 'co-operation' with the tobacco industry, the hospitality industry and other interested parties, will continue to delay any restrictions proposed or imposed by the European Commission or the WHO as long as possible and ensure that legislation does not exceed the absolute minimum requirements, is weak and, where possible, provides loopholes.

In the end, however, Austria will have to change like everyone else. It seems possible, though, that public opinion will change faster than politicians' preparedness and courage to initiate legal changes. A courageous, engaged and determined health minister as in Italy, Ireland and North European countries is presently not in sight. It may be presumed, however, that soon many more European countries will have joined those who are already leading the way in tobacco control. Perhaps rumours of their success will also pass across Austria's borders.

Some approaches will not be open to Austria's decision makers. With the opening of the East to the European market, in particular with four new EU countries bordering Austria, all of them offering cheap cigarettes and "good smuggling opportunities", an active tobacco price policy will be difficult. This problem will also be faced by many other "old" EU countries. Therefore, a uniform price policy for tobacco products for all EU countries may become necessary for Europe wide tobacco control policies.

10 CONCLUSIONS AND RECOMMENDATIONS

10.1 Limitations of the study

Before reviewing what this thesis has contributed, it is first necessary to discuss the limitations of the research. In carrying out this study, different methods (quantitative and qualitative) were used to achieve the diverse objectives. These involved first setting the scene, by presenting a comprehensive overview of past and current tobacco control policies in Austria, identifying key determinants of smoking and describing the health status of the Austrian population with a focus on smoking-related diseases. These paved the way for the main objective: a critical analysis of Austria's tobacco control policy, gaining insight into the powers behind it and its policy implications, so leading to recommendations for the establishment of a comprehensive tobacco control programme in Austria.

The policy analysis is based on a critical analysis of the tobacco control measures that have been implemented in Austria and personal communications with key informants (some also key actors). However, it was impossible to conduct a comprehensive stakeholder analysis as many people would not talk about this subject. In particular, it was very difficult to elicit direct information about the roles and relationships between certain key players. Similarly, the question of why so little has been done in tobacco control in Austria was very difficult to address directly as enquiries were directly or indirectly declined. The tactics varied, such as an absolute "lack of time" for many months (as, curiously, was the case with all but one leading anti-smoking advocates) or "urgent departures" without cancelling the meeting. Others denied all knowledge, missed the point, enquired cautiously if any publications were planned, or reacted in an evasive manner. One even suggested "not to play the detective" as this would "not pay off" – concerns which were apparently not unfounded. Consequently, access to detailed insider information was not possible. Nevertheless, a very few informants were willing to disclose some information, although some wished to remain anonymous.

Constraints in the time available and the permitted length of this thesis, as well as personal characteristics of the researcher regarding technique of questioning also help to explain why a detailed stakeholder analysis could not be performed. In-depth interviews with all key actors require much patience and persistence, a well-founded political background knowledge (which, in the case of the researcher, developed only over time) to focus the questions, and, above all, a more aggressive, "journalistic" approach.

Apart from unwillingness to answer "unpleasant" questions about Austria's tobacco policy, another limitation is the absence of an anti-smoking "body" such as ASH (Action on Smoking and Health) in the United Kingdom that could offer information and advice.

As explained in the methods section, interviews were carried out in German and direct quotes were translated into English by the author. Similarly, abstracts from letters, laws, newspaper articles, homepages, or other documents were translated from German into English by the author. Although careful attention was paid to avoid changed meanings during translation, slight changes may have occurred.

The quantitative data used in this study include survey data and data from mortality statistics and the cancer registry, the last two being received from the national statistics institute. These statistical data can be considered good quality and were used for further computations on lung cancer mortality *(see contributions)*.

However, some limitations with regard to survey data need to be acknowledged. Data on smoking prevalence and smoking behaviour from the microcensus can be considered representative but are not entirely comparable with other surveys because of differences in statistical methods and in some questions. Other surveys differ in their questions, sampling techniques, size, and method of analysis from survey data used for European comparisons (e.g. HBSC, Eurobarometer). Thus data on smoking prevalence can only be interpreted as an estimate and comparisons must be undertaken with great care.

A more detailed analysis (using logistic regression) of determinants for smoking was performed on the data set of the Vienna Health and Social Survey to which the researcher had access to. Although every effort was made to make the most of these data, it must be acknowledged that the quality of data is limited. Available survey data on smoking in Austria are limited and there is no information on attitudes and beliefs, etc. *(see further research)*.

Another limitation of this thesis is the fact that, although many findings from elsewhere can be generalised and applied to the Austrian tobacco industry (in particular since the takeover of *Austria Tabak* by the British tobacco company Gallaher), the researcher had only access to documents from the international (American) tobacco industry, sometimes reporting about *Austria Tabak* or company members, but only few documents from the Austrian tobacco company itself.

Perhaps the greatest limitation is, however, the limitations on length imposed by the regulations for this degree. At the outset, it was not anticipated that so much information would be obtained, so that the draft thesis became much longer than intended. As a consequence, it has been necessary to move much of the material into appendices, which it is conceded compromises the flow of the text.

10.2 Contributions of this study

Austria is a country subject to remarkably little public health research. While recognising the limitations of this study, noted above, it does make several new contributions to knowledge. For the first time, a comprehensive overview and analysis of tobacco policies in Austria has been undertaken. In addition, by performing logistic regression on data for Vienna, it is the first time that anyone has looked in such detail at determinants of smoking in Austria. It is also the first time that anyone has performed a cohort analysis on lung cancer mortality in Austria.

Most important, however, is the study's contribution to the limited international knowledge about Austrian policy on tobacco control and the understanding of this policy within the wider framework of the tactics of the tobacco industry, the evidence on tobacco control measures, and EU legislation.

Insights into policies were gained by analysis of Austrian media reports on smoking-related issues and television discussions on tobacco control measures, analysis of tobacco industry documents with relevance to Austria, discussions with policy makers and key informants, personal communication and information gathering from various experts and bodies.

By these means, the study provides additional evidence about tactics and strategies of the tobacco industry, confirming findings from other countries about involvement of government and scientists in pursuit of the industry's goals.

A major contribution of this research is the discovery of how social, inter-personal and individual factors, but also economic issues are crucial elements in health policy making in Austria, and possibly in other countries as well. What makes Austria possibly more interesting is the strong interweaving of the small number of key players, mostly due to party-political ties and personal relationships, which makes it very difficult to get useful information about powers behind policymaking.

The most important strength of this research is its comprehensiveness, using a variety of methods and thus allowing a better assessment of Austria's policy-making in relation to tobacco control. This, however, is an area that still requires further research *(see later)*.

10.3 Implications for policy

Experience in many countries has shown that influencing smoking behaviour requires a range of specific interventions linked in a comprehensive tobacco control programme. The goals of tobacco control measures are, however, not only changes in smoking behaviour but ultimately a decrease in smoking-related disease incidence and mortality.[366]

The aim of this thesis was to analyse Austria's tobacco control policies, identify the forces behind them, and develop a set of recommendations for comprehensive tobacco control. We have seen that party-political ties, economic considerations, and close relationships between the Austrian tobacco industry, the government, and leading "anti-smoking advocates", experts and scientists have hampered the development of an effective tobacco control policy in Austria. Compared to many other European and overseas countries, Austria's tobacco policy lacks both political will to implement effective measures to reduce smoking prevalence and to protect non-smokers from the hazards of tobacco smoke. A call for action is necessary.

Based on scientific evidence about health effects of active and passive smoking and evidence on the effectiveness of tobacco control measures implemented in other countries, several measures have been shown to be very effective in reducing tobacco consumption and ultimately also tobacco-related mortality and disease burden. However, single initiatives have been shown to be insufficient. As these measures reinforce each other, several should be implemented simultaneously. The maximum impact comes from a combination of education and information, legislation, taxation, media campaigns, professional involvement, prevention and cessation programmes in various settings, bans on smoking in all public places, and a complete ban on advertising and promotion of tobacco products. Thus, sustained, comprehensive policy elements are crucial, as well as earmarked funding maintained over a long period of time. The ultimate goal, therefore, is a comprehensive tobacco control plan that becomes a permanent part of the public health infrastructure.

The following measures have been shown to be effective elements of a comprehensive tobacco control policy:[132 367 368]

- Increased tobacco taxes (and thus cigarette prices).
- Implementation of smoke-free environments in public places, including restaurants, pubs and bars, to reduce both smoking prevalence and health hazards from passive smoking.
- Increase of information and building of public awareness by population-wide campaigns with adequate, long term funding and ability to administer the campaign free from political interference, including ASH-type public information campaigning with ongoing media advocacy.
- Advice and support for treatment and cessation, training of health professionals.
- Ban on advertising, promotion and sponsorship of tobacco products.
- Product control and consumer information.
- Fighting illicit trade in tobacco products on a pan-European level.
- Reduction of availability of tobacco products to young people (regulations on distribution) and of opportunities to smoke (smoke-free environments).

The strategic approach should be population-based, aiming to make non-smoking behaviour the norm and thus lowering the risk in the entire population. As outlined in the 2002 WHO World Health Report, "small shifts in some risks in the population can translate into major public health benefits".[2] As Geoffrey Rose noted, "it makes little sense to expect individuals to behave differently from their peers". It would be "more appropriate to seek a general change in behavioural norms and in the circumstances which facilitate their adoption".[369] However, changes in social norms and the social environment of local communities must come from the grass-roots and, while the state can foster a supportive environment, this cannot be mandated from the top.

Sound research and evidence are extremely important as a basis for good policy decisions. In many countries, generating and publishing a solid information base proved enormously useful to policymakers and advocates and helped promote changes in public attitudes and awareness that gradually led to changes in social norms. A comprehensive and integrated programme of surveillance has often been a key component, addressing a wide spectrum of planning, implementation, and evaluation needs.[370] Therefore, monitoring, evaluating, and reporting on tobacco use and tobacco control policies should be an additional part of a comprehensive tobacco control programme.[132]

When developing measures to reduce tobacco consumption one has also to take account of the established strategies adopted by the tobacco industry, in particular with regard to concealing and distorting evidence and confusing and misleading the public (and thus also health politicians) about the health impacts of active and passive smoking.[27,371] Continued awareness raising

among the public is therefore an important step preceding and accompanying anti-smoking measures. Another successful strategy of the tobacco industry one should adopt is the practice of lobbying.

Particularly for reluctant countries such as Austria, strong and binding EU legislation on smoke-free environments in public places (especially smoking in the workplace, including restaurants and bars) could be important to stimulate changes, with pressure from other countries (so Austria can no longer exclude itself) and the public (pressure groups and increased demand by customers, including tourists), making economic interests the thriving force. Although 25 years later, the situation today is not much different from 1979, when a Philip Morris report stated: "No major change in the present situation of Austria can be anticipated. However, any increased spill-over effect from other countries concerning the health question might force the Austrian Government to reconsider its position."[104]

The assessment of the success (or failure) of Austrian tobacco policies was examined within the wider framework developed by the WHO's European Strategy for Tobacco Control (ESTC), which is based on the best available evidence, and on the lessons learnt from European and international experience.[132] Although Austria agreed with its signature to the Warsaw Declaration and the WHO Framework Convention on Tobacco Control to allocate a share of tobacco tax revenues to anti-smoking campaigns and to develop a comprehensive tobacco control programme, nothing has happened as yet and there are no signs that this will change. It is a striking fact that Austria has been concentrating its already very limited efforts in measures that are widely known to be not very or not at all effective, or even counter-effective – and still defends this approach. Particularly over the last decade, campaigns have only been targeted at youth, and have been very small-scale and mostly conducted in a patronising manner, while those measures recognised as effective are mocked, brushed off or contested. Legislation is weak, smoking prevention has become synonymous with treatment for severely ill smokers, cessation is not an issue, and tax revenues from tobacco products are used to balance budgets and finance health promotion projects but are not earmarked for anti-smoking campaigns or tobacco control measures. The next section therefore proposes recommendations as to what steps are needed to implement an effective and comprehensive tobacco control programme in Austria.

Smoke-free legislation, clean indoor law

International experience demonstrates how comprehensive legislation is absolutely crucial to achieve effective tobacco control. Generally, legislative measures are far more effective than

voluntary agreements. The latter usually only work where there is strong economic or other external pressure that makes the *status quo* no longer tenable (as shown, for example, with non-smoking flights by Austrian Airlines or smoking restrictions at Vienna Airport). Furthermore, to be effective, legislation must be coupled with an emphasis on implementation and enforcement, including substantial fines and other sanctions.

To achieve smoke-free environments in the hospitality business strong and binding laws are needed, whereas ventilation, voluntary agreements and partial smoking bans have been shown not to be effective.[135] Additional benefits of smoke-free environments include a decrease in smoking prevalence and in tobacco-related morbidity and mortality (above all cancers and cardiovascular diseases).[366]

In Austria, discussion of smoke-free environments at workplaces (including restaurants, pubs and bars) is dominated by the viewpoint of smokers. Instead, the rights of the majority non-smoking public should have priority. There is also no reason why this should not apply to hospitality employees.

Although laws restricting smoking in some environments do exist, they are often vaguely formulated, barely adhered to and not enforced. Almost all of these bans are in laws and regulations other than the Austrian tobacco act, such as the employees' protection act or the local public transport regulations, or are individually regulated by the hospital or school management. Austria's health politicians are strictly opposed to smoking bans in restaurants and bars, while relying on the market and favouring the voluntary agreements advocated by the Austrian tobacco industry and hospitality industry. Arguments are either based on the "tolerant" view that "these kind of laws" are not needed in Austria or on the misplaced fear of economic damage to the hospitality business. There is a current danger of pre-emptive legislation, suggesting that only premises above a certain size should be obliged to offer a non-smoking environment. There is no discussion of making non-smoking the norm and separating smokers in specially designed rooms.

Smoke-free environments have been successful not only in the notorious United States (in Austria widely cited as an example of extremist and puritanical measures) but also in Canada, Australia, New Zealand, and in many European countries. It can be demonstrated that not only non-smokers benefit from smoke-free legislation, but also smokers themselves: first, smokers smoke less; second, smoke-free environments offer a greater chance to quit; third, there is less need and less opportunity for young people to start smoking; and fourth, the public (including smok-

ers) will support legislation once enacted. Public approval following introduction of smoke-free environments in restaurants and bars is reflected in results of surveys as, for example, was shown in Scandinavian countries or in Australia.[a]

Conducting a population poll before enactment of smoke-free legislation, especially after a phase of sensitisation to counteract continued misinformation of the public, could make a strong argument for the implementation of smoke-free environments in all workplaces, including restaurants and bars. At the same time the public would see that it is the preference of the majority and not the pressure of a few "intolerant" and "militant" non-smoking fanatics or a patronising law forced upon the people. Thus the role of the media becomes very important.

Ultimately, it will probably not only be a question of laws but rather a change in public attitude and social awareness, in particular of an increased awareness and self-confidence of non-smokers. Therefore, what is most needed in Austria are strong educational campaigns to influence the public opinion and strengthen the rights of non-smokers rather than those of smokers; to convince patrons, employees as well as customers of the benefits of smoke-free environments in the catering business; to help make non-smoking the social norm and smoking the exception; and to enact comprehensive smoking bans in all workplaces, backed by significant sanctions.

Taxation

Taxation is another most effective measure to control tobacco consumption, particularly among children and young people while also raising money for the government. Tax revenues can also be used to finance comprehensive and sustainable educational campaigns and treatment.

Information, educational campaigns and public awareness building

The third pillar in an effective tobacco control policy is information and education of the public. This should involve large-scale, multi-level, long-running and aggressive mass media campaigns, targeted at the whole population, supplemented with group-specific and more narrowly focused campaigns targeted specifically at children, youths and women, the main targets of cigarette advertising. Media campaigns are not only known to be successful transmitters of educational programmes but crucial in any tobacco control programme. Success depends on intensity of measures and aggressiveness of implementation. Administration of state-level cam-

[a] One Australian survey was even conducted by Philip Morris but, due to its unhelpful results, was not advertised.[372]

paigns should be free from political interference[368]. Very effective proved ASH-type public information campaigns with intensive media advocacy.

The ultimate goal of information and educational campaigns is a change in social norms, declaring smoking to be "out" and altogether an irresponsible behaviour, and to build up public awareness not only towards health hazards of smoking, but also towards hazards from passive smoking and towards advertising strategies of the tobacco industry (exposure of tobacco industry tactics allows smokers to feel they are victims rather than villains). The latter should in particular address the marketing of low tar cigarettes and the disclosure of the "light cigarette lie", which aims to reassure smokers and deter them from quitting. In addition, due to skilful marketing and very attractive packet design, cigarettes have a strong appeal, especially to young people. Therefore, campaigns would also have to include broad and continued counter-advertising.

Population-wide campaigns should offer information about and support for quitting *(see below)* while prevention campaigns would have to start already with young children. Along with a change in social norms, long-term goals would be a decrease of smoking rates and an increase of ex- and non-smokers, and ultimately a decrease in tobacco-related diseases and mortality.

The argument that there are insufficient funds for these admittedly very expensive campaigns can easily be countered with a substantial tax raise for all tobacco products and the allocation of a certain amount of tobacco tax gains to fund campaigns. In addition, fines for violating smoking bans or other tobacco laws could be used for anti-smoking activities. These extensive and long-running campaigns would also counter the continuing argument against tobacco advertising bans concerning purported losses by the advertising industry, as these losses would turn into gains.

Cessation

The fourth pillar is the promotion of cessation, which as yet is not an issue in Austria. The importance of quitting can now be seen to be more important than ever in the light of the recently published follow-up to the British doctors' study.[373] Cessation is not advertised and existing initiatives are not supported. There are virtually none of the helplines or quitlines that exist in other countries. Medical students, doctors, pharmacists and other health professionals are not trained in advising and supporting smokers to quit.

A stronger approach to cessation is thus essential, including information on possible cessation techniques, contact numbers (helplines), and advertising of effective products (the latter would

also contribute to awareness building). Specific training courses for health professionals should be offered to increase their involvement in cessation and improve support. High-quality courses for leaders of smoking cessation courses are also needed. As yet, the involvement of health professionals in cessation is very modest. The fact that smoking is primarily an addiction and not a matter of "choice" and "pleasure", should be stressed. It has also to be pointed out that cessation is the only proven way to reduce illness and death caused by tobacco products. The implementation of helplines and quitlines would be essential and one of the less expensive first steps in tobacco control; even if not very successful initially, use of both, quitlines and cessation programmes increase after the onset of anti-smoking campaigns.

Examples for a stronger approach to cessation are reported from Norway, where Week 3 and Week 36 have been established as regular weeks for starting six-week cessation courses, or from Finland, where bigger pharmacies have their own advisor specialising in smoking cessation.

Recommended steps

In summary, the following steps are recommended as a comprehensive tobacco control programme in Austria.

Pillar 1: Legislation

- Clean indoor air law, with non-smoking being the norm and smoking the exception (specified and clearly divided rooms for smoking). Prevention of pre-emptive legislation. Smoke-free environments in all workplaces, including restaurants, pubs, bars and cafés. Similarly, smoking bans in all public buildings, including airports, train stations, etc. – controlled by officials, with fines.
- Complete ban (with enforcement) for advertising and promotion of tobacco products, as well as ban on sponsorship.

Pillar 2: Taxation and financing of anti-smoking campaigns, cessation and treatment

- Sharp tax rise on all tobacco products.
- Allocation of a certain amount of tobacco tax revenues to anti-smoking campaigns and tobacco control measures, cessation (courses, helplines, quitlines) and treatment.

- Sharp increase or imposition of substantial and rigorously enforced fines for violations of advertising bans and smoking bans. Present (and not enforced) fines[b] should be increased at least 10- or even 20-fold. Revenues from fines should be earmarked for tobacco control measures.

Pillar 3: Anti-smoking campaigns, information, education, public awareness building

- Launch of strong, multilevel, broad, sustainable, i.e. long-term orientation, and aggressive media anti-smoking campaigns, targeting the whole population. Information campaigns should include ASH-type media advocacy and media advertisements should be targeted at different audiences. As with all campaigns, they should have a clear goal and be kept "simple". The use of a popular slogan is recommended, either the old "same without smoke", or another good one (in German language). Campaigns should encompass education about health hazards of smoking, information about and support for cessation, strong advertisements targeting tactics of the tobacco industry, and building public awareness about passive smoking hazards. They should also address false hopes that "light" or "low-tar" cigarettes are less harmful.
- Long-term goals should be a change in social norms, in particular that smoking is not only unhealthy but altogether an irresponsible behaviour, leading to a decrease in smoking rates and an increase of ex- and non-smokers, and ultimately the decrease in tobacco-related diseases and mortality.
- Youth prevention is important but will only work when part of a population-wide campaign. It would also have to start at a much earlier age than it is done now, i.e. at primary school. In particular, campaigns addressed at teenagers should not be patronising or pretend to make non-smoking appear to be "cool" or demonstrate "real" self-confidence. Education about the tactics of the tobacco industry and how cigarette advertising works should be crucial elements of all campaigns, regardless of age. In addition, youth prevention programmes "should not shy away from anti-tobacco advertisements that feature the serious consequences of smoking. These types of ads *[advertisements]* are the ones perceived as most effective by teenagers regardless of their smoking status, age, sex or ethnicity."[374] Adolescents and youths are also very aware of adult-focused, i.e. population-wide campaigns, thinking it relevant to them.[375] It can be assumed that youths probably respond even better to adult-focused campaigns than to youth-specific school-campaigns. The latter should therefore be concentrated on younger children.

[b] Present fines stipulated by the 1995 Tobacco Act are only restricted to violations of advertising restrictions (approximately €7,000 for a first and approximately €14,000 for repeated violations). The Vienna local transport regulations foresee fines of €40 for smoking in underground stations.

- Varying, impressive and highly visible health warnings on cigarette packs accompanied with illustrative photos (power of images).
- Sensible presentation of portrayals of real life scenarios of people going through treatment for smoking-related diseases in the mass media (TV, newspapers). They evoke strong emotional reactions and have proven to be memorable and powerful tools.
- Promotion of feeling of responsibility of smokers towards non-smokers (not only "politeness" and "courtesy" but irresponsible behaviour).

Pillar 4: Cessation

- Promotion of cessation is most important when aiming to reduce smoking prevalence. The establishment of quitter telephone lines, offering objective information on all cessation techniques, support or even intervention, is an essential first step to support cessation.
- Advertisement for quitting on posters at point of sale (together with tobacco advertisement, where the latter is not yet banned completely), in pharmacies, underground trains, magazines, etc. Advertisements should include information about various cessation techniques and provide contact addresses or telephone numbers (helplines, quitlines) for advice and support. The fact that smoking is an addiction and not a matter of "choice" and "pleasure", and that cessation is the only proven way to reduce illness and death caused by tobacco products, should be stressed.[376]
- Promotion of effective treatments for tobacco dependence by health insurance funds.
- Training of leaders of smoking cessation courses and health professionals (but not by experts with close relations to the tobacco industry).
- Establishment and advertisement of certain weeks every year for starting cessation courses all over the country, following the example in Norway.

Strategy

1. Preparing the ground

- Design and strategy planning for a comprehensive tobacco control plan.
- Education of the public and awareness building: advertising campaigns, well-briefed media, public opinion polls (public opinion usually favours tobacco control once the issues are explained).
- Moral and financial support of non-smokers' rights associations and other civil society anti-smoking groups.
- Lobbying, allies and coalition building: Collaboration between government and health authorities, NGOs, civil society groups, and committed individuals is essential. Trying

to gain allies in the catering industry trade unions, making them aware of their right to have a smoke-free workplace. Commissioning of studies on employees of the hospitality business (can be used for public awareness building and justification for clean indoor air law). Winning mass media over to smoking prevention campaigns.

- Neutralising opponents (framing message to own advantage).

2. Swift and concerted action, decisive and forceful

- Raise tobacco taxes.
- Onset of aggressive, multilevel, broad, and long-term oriented media anti-smoking campaigns, targeting the whole population. Stress on cessation and information about possible support.
- Simultaneously group-specific campaigns, targeted at young children and women.
- Clean indoor air law with provision of sanctions (to be enforced), preceded and evaluated by a population poll.
- Complete ban on advertising, promotion and sponsorship, demonstrating that alternative sources of sponsorship does emerge.

10.4 Further research

Although wide-ranging, providing insights into many aspects of Austria's policy-making on tobacco, this study has scratched only the surface. Research on tobacco and health is still extremely sparse in Austria.

Deeper research into the powers behind decision-making process and into the apparent role of key players is needed to fully understand the failure of Austria's tobacco control policies. Therefore, a more detailed stakeholder analysis in particular on the role of government (i.e. certain politicians), media, NGOs, opinion leaders and scientists, health insurance funds, the pharmaceutical industry and, of course, the tobacco industry would be necessary.

More and better surveys are badly needed to provide information not only on smoking prevalence but, in particular, on attitudes and beliefs, the development of the "smoker career", and cessation efforts. Among children there is a need for surveys that assess attitudes towards smoking and, to understand the impact of advertising and sponsorship, studies of brand recognition, as, for example, was done in a survey in Turkey among primary schoolchildren.[377]

There is also a need for more research on the future impact of tobacco on disease and mortality[7] [378], in particular the development of models that can predict the scale of future mortality reduction achievable through smoking cessation as, for example, done by Mulder *et al.*[379].

Another important area for further research is to measure exposure to environmental tobacco smoke and thus to estimate the attributable burden of disease due to passive smoking in the Austrian population, as in the 1998 German Environmental Survey[380], studies on the impact of passive smoking on employees of the hospitality industry[155] [156] and on never-smokers living with smokers[381].

More studies are also needed to assess the net economic burden of smoking[382] and passive smoking in Austria.

More detailed work is also needed for surveillance of strategies of the tobacco industry to circumvent anticipated advertising bans by strengthening existing brands, product alterations, and stretching loopholes in the legislation as far as possible. According to a study by Carter, who analysed 172 tobacco industry documents, "a range of activities have been used in combination, including guerrilla marketing, advertising in imported international magazines, altering the pack, sponsorships, brand stretching, event promotions, lifestyle premiums, and the development of corporate websites".[383] Thus, the development of a prospective monitoring system well in advance of the implementation of a total advertising ban would be necessary.

Lessons learnt

In the process of this research I have learned a great deal about methods, study design, technical aspects of scientific writing, the manipulative tactics of the tobacco industry, and Austrian politics, but also about myself.

By performing logistic regression and cohort analysis and collecting and analysing qualitative data, I have developed new methodological skills. In particular in the process of information gathering, due to the absence of real willingness by people to engage in a debate on tobacco control policies in Austria, I realised my own limitations, both with regard to "insider" and party-political background knowledge and my technique of questioning evasive key actors. As noted in the limitations of this study, this would probably need a more "professional" or "journalistic" approach. However, this is increasingly difficult to do with the extension of ethical models based on biomedical research, in which those formally interviewed are considered research subjects and so must be excluded unless they give written informed consent. This is a

matter that requires further discussion if more detailed research in contentious areas such as this is to be pursued.

However, by experiencing these difficulties, I have learned much about Austrian politics and, in particular, health policy. I have thus realised the strong forces behind the decision-making process in relation to tobacco control in Austria. Another insight was the confirmation that, in the field of health, only a small number of individuals, occupying key positions, exert influence and control – on policies, media coverage, public opinion, studies and study results. In addition, Austria's health politicians, health experts, and officials working on tobacco control and health promotion in the Health Ministry (even if, occasionally, they are physicians), have very limited public health expertise. Either they are guided by their own opinion, driven by "external forces", or influenced by experts who play a double role. Finally, while until 2000, tobacco control policies were dominated by party-political ties and the fact that Austria's tobacco industry was a state enterprise, the new conservative government stresses more outspoken economic interests (now *Austria Tabak* is just one among several big companies to be courted for taxes, employment, etc.).

These insights lead me to conclude that only a very dedicated and courageous health minister, building on a sustained programme to increase awareness among the public about non-smokers' rights, and linked to pressure from other countries (including complaints by tourists and thus economic pressure), and, most importantly, strong and binding EU legislation will be able to force Austria to confront its complacency and so to implement effective measures to reduce smoking and protect non-smokers from the hazards of tobacco smoke. The very recent (June 2004) shift of the Health Minister towards a more "rigorous" approach towards smoking in the workplace and possibly also in restaurants, pubs and bars, following discussions on the Irish smoking ban and in anticipation of new EU legislation on smoke-free environments, confirms the well-known Austrian motto, first coined by Habsburg Emperor Frederick III (1440-1493)[384] and re-interpreted by Frederick II of Prussia, that Austria will "always survive" – or, according to another interpretation, will be "the last one":

AEIOU – Austria Erit In Orbe Ultima.[c]

[c] "Austria will be in existence until the end of the world". But also: "Austria will be the last (of all) in the world."

APPENDICES

APPENDIX A

Austria Tabak (Gallaher Group Plc): The company

Austria Tabak (or *"Österreichische Tabakregie"* or *"Austria Tabakwerke AG"*, as the company was formerly named[a]), Austria's tobacco manufacturing association, was a state-owned enterprise until 1996. It is one of the oldest companies in the tobacco business, with the tobacco monopoly having been established in 1784 by Emperor Joseph II. The company also prides itself for having the oldest tobacco research laboratory in the world, established in 1851.[71] Remaining a state-owned monopoly for manufacturing and selling tobacco products for over 200 years, *Austria Tabak* was privatised in 1997, following EU accession.

In April 1939, the company was turned into a stock corporation *(Austria Tabakwerke AG)*, with 100% of the stocks owned by the state. In 1996, the Republic of Austria transferred the whole block of shares to *Österreichische Industrieholding AG (ÖIAG)*, the Austrian state-asset holding company, with instructions for a majority privatisation of *Austria Tabak* by 1999 at the latest. On 5 November 1997, *Austria Tabak* was partly privatised.[b] In January 2000, following the accession to power of a right wing coalition, the Conservative Party (ÖVP) and the Freedom Party (FPÖ) planned a reorganisation of *ÖIAG* in their new government programme, commissioning the *ÖIAG* management to develop a multi-year privatisation programme that would transfer 100% of the government-owned stocks of several companies, among them *Austria Tabak*, to new owners, strategic partners, or the public.[c] [386] Talks to find a new owner for *Austria Tabak* were initiated in the autumn of 2000; in the night of 21/22 June 2001 the British tobacco group *Gallaher* was chosen as the new owner. The contract was signed immediately thereafter. Subsequently, 41.13% of the stocks still held by *ÖIAG* were released to the British tobacco company *Gallaher Group Plc*, who paid £1.14bn (€770 million).[23] [386] Between its takeover in June 2001 and the end of that year, Gallaher had taken over the remaining shares of its subsidiary Austrian Tobacco at a price of €85 per share, totalling €1.1bn, making it the largest takeover in Austria since the beginning of 1999.[23] [387] Altogether, the company was sold for the sum of only five times its annual profit, an issue that has attracted criticism ever since.

Before privatisation, Philip Morris Inc., R.J. Reynolds International, British American Tobacco (BAT) and Reemtsma were all licensors to *Austria Tabak*. All had expressed interest in the company. It was expected that, if one of the international cigarette manufacturers would buy

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[a] In 1784 *Austria Tabak* was founded by Emperor Joseph II with the designation *"Österreichische Tabakregie"*. In 1939, after transformation into a 100% state-owned joint stock company, the company was renamed into *"Austria Tabakwerke Aktiengesellschaft, vorm. Österreichische Tabakregie"*. Today, after the taking over of Austria Tabak by the British company Gallaher Group Plc in 2001, the company is called *"Austria Tabak AG & Co KG – Continental Europe Division"* (AT/CED), or *"Austria Tabak Gallaher"*.[70] In this study, the company is generally referred to with the commonly used name *Austria Tabak*.

[b] *ÖIAG* placed 49.5% of the capital stock on the Vienna Stock Exchange through an Initial Public Offering, the issue price of €37.00 being below market estimates[385]. Approximately half of the shares were bought by institutional and private shareholders in Austria, the remaining stocks were distributed among institutional investors in Great Britain, Germany, Switzerland, France, Italy, the USA, and other countries. On 25 March 1999, another 9.4% of the capital stock was released by way of a block trade, making the majority of *Austria Tabak* privately owned. The shares were bought primarily by institutional investors in Great Britain and the USA.

[c] These companies included the government's printing office *Staatsdruckerei*, the auction house *Dorotheum*, *Print Media AG*, the government-owned airport stocks of *Flughafen Wien AG*, the post bank *PSK* (with the participation of *Post AG*), *Telekom*, and *Austria Tabak*.[386]

Austria Tabak, the other three licensors would cancel their license agreements. In anticipation, *Austria Tabak* signed new production agreements with Philip Morris Inc., its main licensing partner, on 6 June 1997 and with its other three major licensing partners in August 1997. The European Commission approved the extension of the company's license agreements in March 1998, with 36%, i.e. some 4.5bn cigarettes of total output, accounted for by agreements with its four licensors until at least 2008.[72]

In the early 1990s, *Austria Tabak* decided to build up an independent tobacco wholesale business division, which today operates in Austria, Germany and Hungary. Between 1990 and 1997, *Austria Tabak* bought *Tobaccoland Germany* in several stages; in 1993, it bought the Hungarian company *Goldfilter*, today *Tobaccoland Hungary*, so entering the Hungarian Market.

In 1997, when still half government-owned, *Austria Tabak* was the sole producer and distributor of tobacco products in Austria, controlling 59% of the domestic tobacco market. In addition to tobacco manufacturing, *Austria Tabak* was also the sole tobacco wholesaler in Austria, the leading tobacco wholesaler in Germany, and it also owned a wholesaling operation in Hungary.[72] *Austria Tabak's* tobacco manufacturing division produced cigarettes at three Austrian factories and one small factory in Malta (opened in 1984), which has now closed down and serves only as importer and wholesale dealer for *Austria Tabak Gallaher*.[73] It also had built up business relationships with Japan, China, Cambodia, Taiwan and Russia, already anticipating that these countries had a potential for market growth that could offset stagnating and/or declining sales in Western Europe.[72]

Until EU accession in 1995, the Austrian market was thus characterized by a full monopoly, comprising a) cultivation, b) import and processing of tobacco, and c) import, production and distribution of tobacco products. This was according to the monopoly regulations, last laid down in the *Tabakmonopolgesetz 1968* (Tobacco Monopoly Law of 1968). Trading in tobacco products was exclusively reserved to *Austria Tabak* and those authorized by the company. The distribution by tobacconists was based on sale on commission. The history of the Tobacco Monopoly Law is described in more detail in Chapter 8.[74]

Following new EU legislation (abolition of regulations permitting monopolies in raw tobacco and liberalisation of the wholesale monopoly requiring admission to other wholesalers to the market[74]), the import monopoly was legally abolished on 1 January 1995, when *Austria Tabak* was still a state-owned enterprise (although the company itself had already abandoned it in mid-1994) and the production monopoly was abolished at the beginning of 1999.[269] In 1995, the Austrian wholesale element of the company was transferred to the newly established *Tobaccoland Austria*, intended to operate as a neutral company in the market. Following an unsuccessful strategy of diversification and a financial disaster after the acquisition of the company *Head-Tyrolia-Mares* (a maker of sports equipment), *Austria Tabak* backed out of the sports goods business. In the same year, it disposed of the raw tobacco business, which was established in the 1920s to secure supply of oriental tobaccos, mainly from Greece and Turkey. In 1996, *Austria Tabak* also withdrew from the real estate business.[74] However, as in Italy, France and Spain, a monopoly for retail sales by tobacconists still exists, its administration being subordinated to the Federal Ministry of Finance.[24] As this discussion makes clear, although privatised, the tobacco trade has brought large incomes for the state (whether through share of profits or taxes), which makes the state, understandably, rather reluctant to fight tobacco consumption.

Today, *Austria Tabak* belongs to Gallaher, placing this company in top spot in Austria and Sweden and making it the 4th largest cigarette manufacturer in western Europe, and the 6th largest in the world.[23] The company had chosen Vienna as the head office of the Continental

Europe Division (CED) with responsibility for 35 countries in Europe, except UK and Ireland. The area ranges from Portugal in the West all the way to Hungary in the East, from Scandinavia in the North to Greece in Southern Europe. Industrial activities comprise production and marketing of tobacco products, placing Austria and Sweden as home markets for continental Europe and exporting to selected international markets. As a trading company, *Austria Tabak* still holds important market positions in Austria, Germany and Hungary.[23]

In 2002, 46bn cigarettes were marketed in continental Europe from the main office in Vienna, representing 30 percent of Gallaher's total volume sales and contributing £213 million to the Group's EBITA[d]. The most significant brands are Benson & Hedges, Memphis, Blend, Silk Cut, and Ronson. In addition, the CED is very successful as a wholesaler for tobacco products in collaboration with its *Tobaccoland* subsidiaries in Austria, Hungary and Estonia. In Germany, *Tobaccoland* cooperates with *Lekkerland* and holds a majority share of *Tobaccoland Automatengesellschaft* (a cigarette vending machine enterprise).[23] Consequently, in "Tobaccoland Austria" tobacco sales are rising. A three year Philip Morris distribution contract is seen as guaranteeing continued success.[23]

Continental Europe is seen by *Gallaher* as a platform for accelerated Eurasian growth, with Austria in leading position. According to its annual report on Austria, it has achieved a cigarette market share in Eurasia of 48.6%.[23] *Gallaher* also reports excellent trading performance in Russia, Kazakhstan and Ukraine.[388] At present, *Austria Tabak* is strengthening its profile in Serbia. On 24 April 2003, *Austria Tabak*, which has traditionally had good business relations with Serbia, opened its first sales office in Belgrade. In 2002, five billion cigarettes were sold in this region.[389]

According to company papers, the reasons that *Austria Tabak* was so attractive for *Gallaher* were that it presented itself as an internationally active company, by virtue of the record of its business divisions "Tobacco industry" and "Wholesale" and that it had had placed a high priority on European expansion. Examples of its achievements are listed in a 2003 press release from *Austria Tabak*[386] as follows.

- Acquisition of the cigarette division of the *Swedish Match* on 2 July 1999, thus market leader in Sweden.
- Merger of *Lekkerland* and *Tobaccoland Germany*. As a result, *Austria Tabak* becomes wholesale market leader in Germany as of 1 January 1999.
- Fusion of the vending machine business in Germany, becoming market leader in vending machine operation in Germany with more than 220,000 cigarette vending machines.
- Contracts with Philip Morris for exclusive distribution in Estonia, starting 1 January 2001.
- Attractive own brands such as Memphis, Milde Sorte, Ronson.
- Growth in earnings and production.
- Excellent export success.

Austria Tabak, as the Continental Europe Division of the Gallaher Group, has been a noted success within the group. The 2002 full year results, for instance, document ongoing improvements in international production.[23] Both a production boost from Austria's cigarette factories and a growth in Austria's cigar production can be observed. *Gallaher* reports that in 2002, the

[d] EBITA = Group profit before interest, taxation and amortisation.

underlying productivity of Austrian factories went up by 2.9% and the additional production volumes in the Austrian cigarette plants in Hainburg, Linz and Schwaz created 100 new jobs. There is also one cigar factory in Fürstenfeld. More than 3,700 employees work in its Austrian factories. In 2002, the turnover of the CED amounted to £2.3bn or €3.7bn.[23] The General Director and CEO of the Continental Europe Division, Nigel Simon, has set out a clearly defined mission: "We want to become the most efficient, most effective and most profitable part of the Gallaher Group".[93] *(APPENDIX C.)*

APPENDIX B

History of the Tobacco Monopoly Act

In 1784, more than 200 years ago, the Austrian tobacco monopoly was founded by Emperor Joseph II, designated as *Österreichische Tabakregie*. It was a full monopoly, i.e. crop growing, extraction, processing, manufacture and trade were reserved for the state. At first, it was a state undertaking but soon after, disabled veterans and innocently impoverished civil servants and their next of kin were favoured in the awarding of licences for the sale of tobacco products.[76]

In 1835, the *Zoll- und Staats-Monopols-Ordnung* (Duty and State Monopoly Order) was established, followed in 1911 by a comprehensive decree on the sale of tobacco products. Despite several adaptations as the structure of Austrian government has evolved, this decree remained the basis of the tobacco monopoly until 1949.[76]

In 1949, the new *Tabakmonopolgesetz* (Tobacco Monopoly Act) granted *Austria Tabakwerke AG (ATW)* responsibility for administration of the monopoly. After revision in 1968, this act lasted practically until entry to the European Union in 1995. The only major change to this act was in 1979 when civilian handicapped persons were included in the group who could be awarded the right to run tobacconist shops.[76]

In 1994, after conclusion of the negotiations for Austria's EU membership, the cultivation of tobacco became subject to EU agricultural regulations; only the production monopoly, although of far less importance, remained in place. The wholesale trade was liberalised, but the retail trade remained untouched. On 1 January 1996, the *Tabakmonopolgesetz* (Tobacco Monopoly Act)[390] was enacted by an act of parliament. As an independent authority and the sole owner, the Republic of Austria authorised the Minister of Finance to found the *Monopolverwaltung GmbH* (Monopoly Administration Ltd.), which is to deal exclusively with matters of tobacconist shops. Although it is subordinated to the Ministry of Finance, this ministry has only limited authority over this body, in particular the competence to administer the shares that belong to the Federal Government to 100%.[76]

Initially, as noted in Chapter 3, licences to sell tobacco products were only issued to disabled veterans and impoverished civil servants and their next of kin. During the Nazi period, Jewish tobacconists were dismissed and Nazi tobacconists appointed *(APPENDIX R)*. Today, anybody can apply for this licence in principle; however, physically disabled persons are favoured, with the grade of disability having to be at least 50 percent. Under certain conditions, there is even a right of inheritance. Only when there are no handicapped applicants is the licence issued to other, non-handicapped individuals.[75] This regulation is part of the social legislation in Austria (disability rights). Persons with preference rights *("Vorzugsrechte")* are:

- victims of war, including persons who suffer injuries from unexploded shells in the present time *(Kriegsopferversorgungsgesetz)*
- victims injured in the armed forces, i.e. persons who suffer injuries during military service *(Heeresversorgungsgesetz)*
- other victims *(Opferfürsorgegesetz)*
- disabled civilians (invalids), e.g. persons who have had a traffic accident, accident at work, etc. *(Behinderteneinstellungsgesetz)*

At present, 73% of tobacconists are operated by handicapped persons. While the number of disabled veterans is now, of course, decreasing, the number of persons disabled by other incidents is increasing. Presently, however, due to the 'shortage' of disabled civilian applicants many licences are issued to other persons.[75]

Although tobacco retail monopolies also exist in Italy, France and Spain, Austria is the only country where the monopoly fulfils a social policy goal. This was agreed upon by all major parties parliament in 1995.

Picture 1 *Two different trade signs for tobacconist shops*[24]

APPENDIX C

Tobacco production and sales in Austria

The European tobacco industry

According to the most recent figures provided by the National Manufacturers' Associations as of March 2002, published by the Confederation of European Community Cigarette Manufacturers[39], the value of domestic sales of all tobacco products in Austria amounted to €2.184bn in 2000. The receipt from excise & VAT on all tobacco products was €1.537bn. Austria also shows a surplus of imports over exports *(Table C-1)*.

Although these data do not allow a direct comparison with other EU countries, as country size and population size differ widely, the leading positions of Germany and the United Kingdom, followed by France and Italy, are evident in the following table. In 2000, the value of domestic sales of tobacco products in the whole European Union amounted to almost €95bn, a figure which can now be assumed to be considerably higher and which demonstrates impressively the impact of the tobacco business on the European economy. The tax receipts alone are almost €70bn.

Table C-1 also shows the strong economic interests of some countries when it comes to tobacco control measures. Germany, for instance, by far boasts the highest production of cigarettes; the Netherlands (closely followed by Germany) is leading in the production of cigars and hand rolling tobacco. In the whole region of the European Union, 1.4 million staff were employed in tobacco related business in 2000. More than 605 billion cigarettes were consumed (the largest shares in Germany, Italy, Spain, the United Kingdom and France) and more than 93 million people were reported to smoke in Europe, the majority of them living in Germany, followed by the United Kingdom and France *(Table C-1)*.

Table C-1 The European tobacco industry – facts and figures 2000

Country	Value of domestic sales, all tobacco products (MEURO)	Receipt from Excise & VAT on all tobacco products (MEURO)	Trade in manufactured tobacco products Exports (MEURO)	Trade in manufactured tobacco products Imports (MEURO)	Production of cigarettes (million pieces)	Production of cigars (million pieces)	Production of pipe tobacco (tonnes)	Production of hand rolling tobacco (tonnes)	Tobacco related employment	Cigarette consumption (millions)	Number of smokers (millions)
Austria	2.184	1.537	45.4	301.9	25.431	20.9	-	-	17,000	15,441	1.9
Belgium/Lux.	3.517	1.792*	412.0*	397.0*	19.739	47.2	12,651.0**	-	23,500*	19,739***	2.0*****
Denmark	1.788	1.369	143.0	24.0	11.018	306.0	4,625.0**	-	6,000	9,432	1.7
Finland	978	776	7.1	56.3	3.500	0.5	-	800.0	450	4,659	0.8
France	13.113	9.820	313.0	2,340.0	38.240	625.0	1,478.0	2,675.0	217,759	82,513	14.0
Germany	20.765	14.250	1,779.5	703.1	206.770	1,861.0	791.0	28,725.0	150,000	139,625	20.8
Greece	2.720	1.953	135.0	150.0	41.989	-	13.0**	-	425,000	32,138	3.8
Ireland	1.700	1.289	91.3	36.7	7.000	60.0	-	6,216.0	5,000	6,700	0.8
Italy	12.563	9.256	7.2	1,254.0	44.300	88.0	67.4	-	278,170	100,400	14.0
Netherlands	3.150	2.080	2,100.0	400.0	123.071	2,300.0	350.0	30,700.0	27,500	16,679	4.5
Portugal	1.281	1.085	47.0	1.0	20.383	-	-	-	NA	17,394	1.3
Spain	8.444	5.682	84.1	593.3	68.597	981.0	19.1	147.3	90,000	95,663	11.2
Sweden	1.900	1.250	31.8	114.4	6.000	0	400.0	500.0	3,400	8,500	1.65
UK	20.654	15.920	1,658.0	164.0	126.105	763.0	1,335.0	4,831.0	136,000	56,600****	15.0
Total EU	94.757	68.059	6,854.4	6,535.7	742.143	7,052.6	21,729.5	74,594.3	1,379,779	605,483	93.45

* Only for Belgium.

** Pipe tobacco + hand rolling tobacco.

*** Sales figures.

**** UK duty paid only – total cigarette consumption estimated at 84 billion.

***** 1999 figures.

Source: Most recent figures provided by National Manufacturers' Associations as of March 2002; published by the Confederation of European Community Cigarette Manufacturers (CECCM; Brussels)[39]; table provided by Austria Tabak Gallaher.

Market overview, production and trade

Austria's EU accession in 1995 ended over 200 years of monopoly control of the import, manufacture and distribution of tobacco and tobacco products.

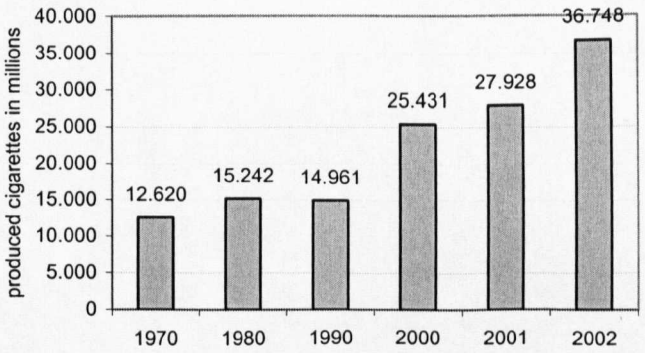
In 1996, the Austrian cigarette market was valued at ATS 21.8bn (€1.6bn). 12.9bn domestic cigarettes were consumed in the same year, 2.3% less than in 1995. In 1997, however, an increase of 5.2% was recorded. On 1 July 1997, new tax regulations were introduced, governing tobacco imports from non-EU countries. As a result, domestic sales of *Austria Tabak's* 39 own and 21 licensed brands fell by 5.5% in the first half of 1997, due to legal and illegal private imports. Smuggling has boomed in Austria, in part reflecting domestic price rises but also the collapse of the former Soviet Union.[72]

In 1997, when still half government-owned, *Austria Tabak* controlled 59% of the domestic tobacco market and was one of the largest wholesalers in Austria, Germany and Hungary. The company controlled nearly all the tobacco and tobacco products market despite losing its wholesale monopoly.[72]

Even now (2003) *Austria Tabak Gallaher* is the market leader in Austria, although the market share is somewhat lower than in 1997 (48.6% by the end of 2002). The most important other players in the market are Philip Morris, British American Tobacco, and Reemtsma. The most important licence partner of *Austria Tabak* for cigarettes is British American Tobacco.[70]

Austria Tabak's Tobacco Manufacturing Division produces cigarettes at three Austrian factories: Linz (Upper Austria), Hainburg (Lower Austria) and Schwaz (Tyrol). It also produces cigars at the factory in Fürstenfeld (Styria), as well as cigarette filters and cigarette tubes. At the end of 1995, *Austria Tabak* shut down its cigarette factories in Berlin and Vienna.[72] The three current cigarette plants produce *Austria Tabak's* more than 60 cigarette brands for both home and export markets. By the end of 2002, 666 staff were employed at the four plants. In 2002, 37 billion cigarettes were produced for both home market and export; only for Austria, the total overturn was 15.3 billion.[70] The marked increase in cigarette production after the majority privatisation in 1999 and particularly after the complete takeover of *Austria Tabak* by Gallaher in 2001 becomes more obvious in the following graph.

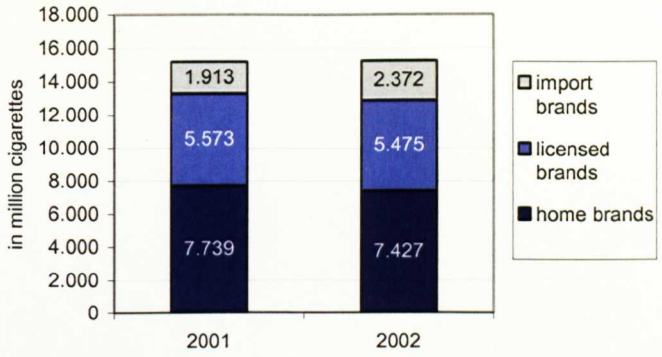
Figure C-1 Cigarette production in Austria, 1970–2002



Source: Austria Tabak Gallaher.[70]

The next figure compares cigarette sales in Austria in 2001 and 2002, showing a marked increase in imported brands while the total amount of cigarettes sold remained more or less the same.

Figure C-2: Cigarette turnover in Austria 2001 and 2002



Source: Austria Tabak Gallaher.[70]

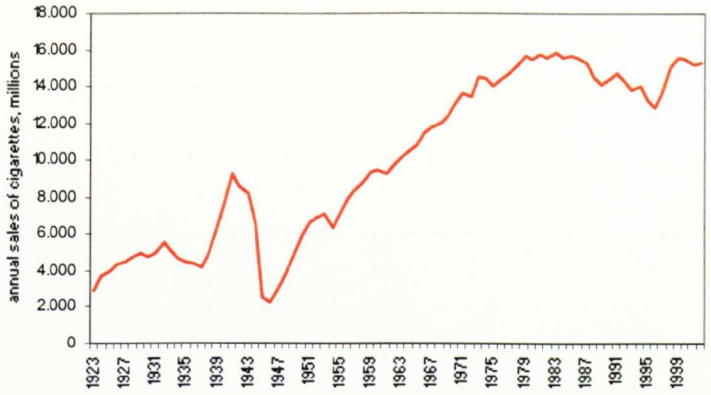
Being the headquarters of the Continental Europe Division of Gallaher, Austria Tabak is now responsible for 35 markets in continental Europe.[94]

Since 1 January 1995, both the number of tobacco producers and the area for tobacco production (mostly burley tobacco) in Austria has declined markedly.[72] Today (end of 2002), tobacco is grown by 69 planters on 113.3 hectare of land in the provinces Upper Austria, Lower Austria, Burgenland and Styria, totalling about 23.3 tons of raw tobacco.[70]

Sales statistics

Between 1923 and 1995, cigarette sales in Austria have more than quintupled (520%), from 2,935 millions sold in 1923 to 15,274 millions sold in 2002. There are, however, clear peaks in the periods 1938 to 1944 (World War II) and during the 1970s and beginning of 1980s. A marked increase since 1997 and even more since 1998 (the beginning of privatisation) characterises the latest developments on the Austrian market *(Figure C-3)*.[70 391]

Figure C-3: Total annual sales of cigarettes, Austria 1923–2002



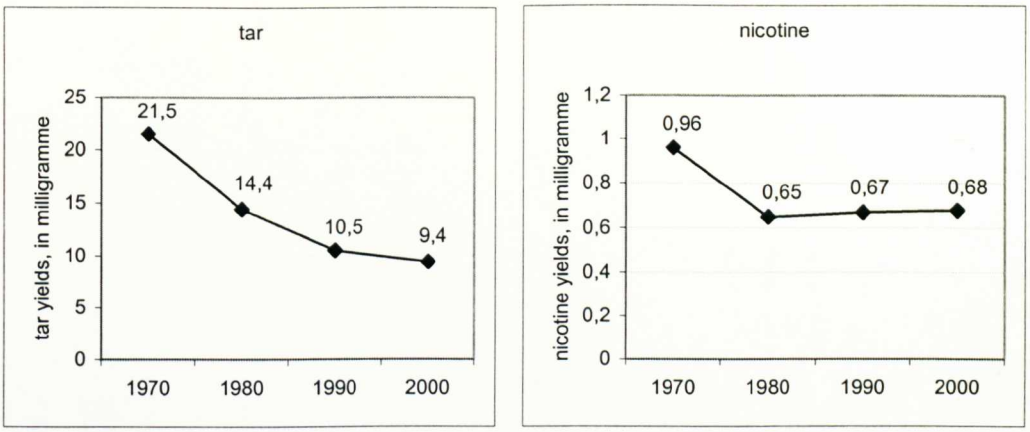
Source: 1923-1995: FOREY et al.[391]; Update (1996-2002): Austria Tabak Gallaher.[70]

In 1960, only 8.8% of all cigarettes sold were filter cigarettes, while ten years later, they amounted to more than 75% and in 1980 to 95%. Since 2000, 99.8% of all sold cigarettes are filter cigarettes;[70] only a few cigarette brands without filter (e.g. Johnny, Flirt, A3, Nil) are still on sale.

Particularly since the mid-1990s, a marked increase in the consumption and sale of cigars and cigarillos can be observed. Between 1990 and 1996, the number of cigars or cigarillos consumed was around 30 million pieces; by 2000, it was already 51 million.[70]

While the quantity of cigarette sales clearly increased, the tar and nicotine yields have been cut markedly (these trends seem to be linked – see section on the myth of light cigarettes in Chapter 3). In 1960, the average tar yield per cigarette had been 33.67mg, in 1970 it had been 21.50mg, in 1980 it was 14.40mg, in 1990 10.5mg and in 2000 9.4mg (2002: 9.4mg).[70] The defined maximum tar yields were 15mg in 1993 and 12mg in 1998. From 2004 onwards, according to the Tobacco Products Directive 2001/37/EC, cigarettes may not exceed a tar limit of 10mg. Similarly, the average nicotine yield per cigarette had been reduced from 1.95mg in 1960 to 0.96mg in 1970, 0.65mg in 1980 and to 0.68mg in 2000 (2002: 0.68mg).[70] From 2004 onwards, cigarettes may not exceed a nicotine limit of 1.0mg (*see Chapter 5)*.

Figure C-4: Average tar- and nicotine yields in Austrian cigarettes, 1970–2000

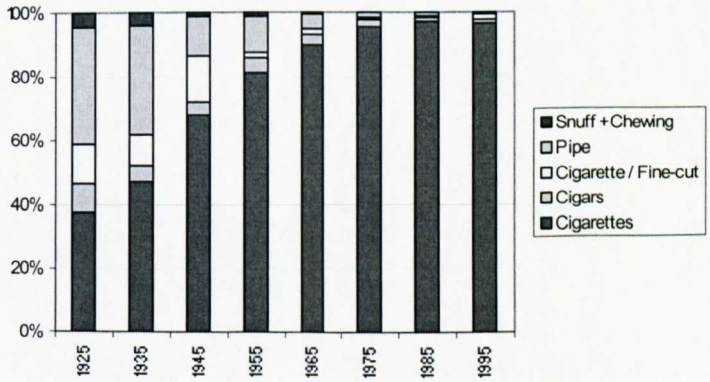


Source: Austria Tabak Gallaher.[70]

Austria's tobacco industry was very successful in lobbying, using the labelling of 'light' cigarettes (low tar and low nicotine cigarettes), and especially the term 'mild' – like, for example, one of its most popular brands Milde Sorte. Other very popular brands are Memphis Light and Marlboro Lights, which were introduced in the market in recent years (list of ranking see below).

Manufactured cigarettes by far dominate the tobacco market since the end of World War II. Pipe tobacco, snuff and chewing tobacco as well as fine-cut tobacco and cigars have become marginal.[391]

Figure C-5: Percentage sales of tobacco in different forms (by weight) in Austria, selected years 1925–1995



Source: FOREY et al.[391]

According to the Federal Ministry of Finance, the taxable turnover of *Austria Tabak* was €1.6bn in 1999, and the taxable turnover of the then roughly 3,600 tobacconists' was almost

€2bn (together €3.6bn).[a] According to *Austria Tabak*, the turnover including tobacco taxes was slightly less, €3.4bn in 1999 and €3.7bn in 2000.[70]

Most sold cigarette brands and market shares

Before being privatised, 94.3% of all cigarettes sold in 1997 were manufactured by *Austria Tabak*, with company-owned brands accounting for almost 60% of the total. Five out of the top six Austrian cigarette brands were *Austria Tabak* owned brands, the rank order being *Memphis* (1), *Milde Sorte* (3), *Hobby* (4), *Dames* (5) and *Falk* (6). The brands *Memphis* and *Milde Sorte*, the company's leading own cigarette brands, together accounted for 67% of all *Austria Tabak's* own label cigarette sales in Austria. *Memphis* achieved a domestic brand share of almost 28% and *Milde Sorte* 11.2%. *Marlboro*, the number two brand, was produced under licence by Austria Tabak.[72]

In 2002, the most popular cigarette market brands sold in Austria were listed by *Austria Tabak* as follows:[70]

1. Marlboro
2. Memphis
3. Milde Sorte
4. Gauloises
5. Hobby
6. HB
7. Dames
8. Philip Morris
9. Camel
10. Casablanca

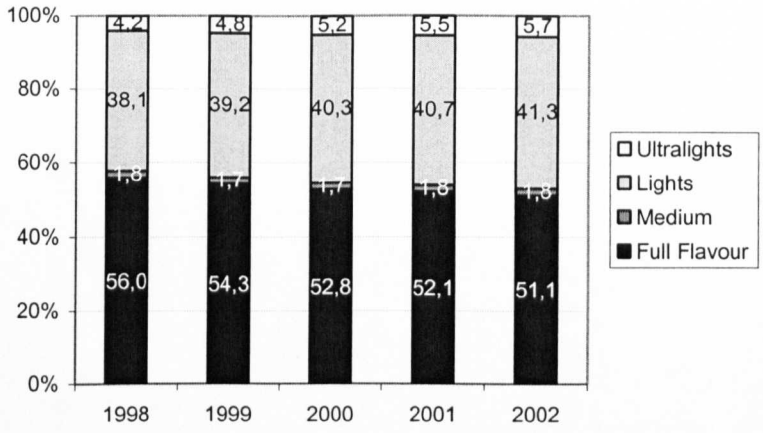
For present market shares (volume) of the leading Austrian cigarette brands no data were provided by *Austria Tabak.*

Between 1994 and 1997, the domestic market share was steadily declining, from 66.7% in 1994 to 60% in 1996 and to slightly more than 59% in 1997. Nevertheless, at that time *Austria Tabak* still had one of the highest percentage shares held by a European tobacco manufacturer in its home market. Before privatisation, the market shares of cigarette manufacturer were as follows: Philip Morris 29.3%, Austria Tabakwerke 55.6%, Reemtsma 3.5%, BAT 4.6%, others 7%.[274] *(No more up-to-date information available.)*

In recent years there has been a clear shift towards 'light' cigarettes. The mild/lights segment has been the fastest growing segment in the Austrian market, following growing health consciousness, which has been stimulated by the well-directed strategies of the tobacco industry. In particular one can see the effects of the implicit: Lights=Mild=Less Harmful.[392]

[a] Not included are sales of tobacco products in restaurants or larger groceries etc.

Figure C-6: Cigarette tar segments 1997–2001, in percent



Source: Austria Tabak Gallaher.[70]

Before privatisation, *Austria Tabak* had 60 out of a total of 101 cigarette brands on the market, including 39 own brands and 21 licensed brands, such as *HB* and *Ernte* (5 are US brands). In 1996, the leading brand family was *Memphis* with a 43.3% market share. *Memphis Classic* was the leading locally-produced cigarette brand on the market, while *Marlboro* was the leading imported brand. Other brands included *Milde Sorte, Maverick, Casablanca, Marlboro Lights, Memphis Lights* and *Hobby* cigarettes.[274]

In 1996, a high priority was given to the expansion of *Austria Tabak's* core brand families, *Memphis* and *Milde Sorte*. However, while leading domestic brands stagnated (*Memphis* at 26%) or declined (*Milde Sorte* and *Hobby*), *Marlboro*, which is manufactured under license, has seen its market share rise by 60% between 1991 and 1996 *(no more up-to-date information available)*.[274]

Every year at least two new brands have been brought to the market. The launches in 2002 were *Memphis Platinum Lights* and *Benson & Hedges Red* (Full Flavour and Lights). In 2003, *Silk Cut* (*Silk Cut Ultra* and *Silk Cut Mild*), *Smart box* (Full Flavour and Light), *Maverick Lights*, *Ronson Lights* and *Smart Box Menthol* were launched.[70]

In 2001, when it was bought by Gallaher, *Austria Tabak* concentrated on American blends. The Austrian bestseller was Memphis.[393] In 2003, *Marlboro* and *Memphis* were still the most sold cigarette brands in Austria.[70]

Until 1997, the market has been characterised by a growth in demand for light cigarette brands, especially the brands *Memphis Lights* and *Marlboro Lights*. According to a recent information from *Austria Tabak Gallaher* (September 2003), the overall market for "light" cigarettes has been fairly stable over the last years, with a slight increase of Lights and Ultra Lights on account of Full Flavour, while Medium has been stable.[70]

APPENDIX D

Industry meetings in Austria

The BATCo-Meetings

The minutes of the BATCo Chairman's Advisory Conference[a] in May 1981 (Pichlarn) disclose the strategies and tactics proposed for dealing with government activities, arguments about the effect of advertising on consumption, ways of resisting advertising and sponsorship restrictions, how to ensure better circulation of favourable reports by respected bodies or individuals, the necessity of recruiting allies, etc. Other central points of this meeting were social acceptability of smoking and the related issue of passive smoking. The soon to be published Garfinkel report, which would disagree with the scientific consensus on the dangers of passive smoking, was heralded and the need for a simultaneous and concerted PR action expressed. Social acceptability was seen as the greatest long-term threat. With regard to tar levels, then still 20mg or even more, the possibility of government action to reduce levels was seen as a threat once a company has accepted the principle of an upper tar delivery limit. It was argued that the industry should resist any restriction, citing freedom of choice for the consumer. Companies were further advised to muster the arguments against showing carbon monoxide (CO) levels on packets and in advertising, as these could lead to renewed attempts to produce a common index figure for tar, nicotine, CO, and others. The importance of Manufacturers' Associations and the significance of activities of working parties were also stressed. National Manufacturers' Associations (NMAs) should be formed or developed wherever possible, being regarded as the best means of securing allies. In addition, action by the NMAs would give the industry a good standing. However, it was also confirmed that personal contacts and visits would remain "a most important means of educating company and NMA personnel in Smoking Issues".[394] Regarding "third parties", such as governments, the press, medical authorities etc., it was proposed to pursue a more open policy on the basis that discussion is better than confrontation. It was recognised that at that time it was not possible to negotiate with WHO but it was hinted that "discreet personal contacts are possible". Discussions with the press, scientists and the medical profession were better left to NMAs. To enhance the industry's credibility, the view of scientists and medical researchers, including the Surgeon-General, who at that time saw lower risks coming from low delivery cigarettes, should be undermined by calling attention to this ambivalence – but, of course, with "suitable restraint". Prospective epidemiological studies in a third world country were perceived as very valuable, and Brazil seemed very obliging. It was pointed out that some tobacco companies considered research on the benefits of smoking. Other items included in the agenda were the need to monitor government activities in schools; although it was well recognised that many educational campaigns were counter-productive, they could not be sure that this was so if begun at the earliest possible age. It was suggested that companies should study "government propaganda", i.e. health education films and, if necessary, take legal action to prevent screening of them. The fact that each company had important contacts with different key individuals was seen as most important, and companies were advised to inform Millbank

[a] Participants were P. Sheehy (Chairman, B.A.T Co. Ltd.); C.H. Stewart Lockhart (Managing Director, B.A.T); E.A.A. Bruell (Director, B.A.T Co. Ltd.); W.J. Dickson (Managing Director, B.A.T / U.K. & Export); N.W. Goddard (Director, B.A.T Co. Ltd.); Dr. I.W. Hughes (Chairman, Brown & Williamson Tobacco Corp., USA); J.L. Mercier (President, Imperial Tobacco, Canada); R.J. Pritchard (Director, B.A.T Co. Ltd.); D. v. Specht (Chairman, B.A.T Cigaretten-Fabriken, Germany); K.M. Sumner (Vice President, Companhia Souza Cruz Industr. Comercio, Brazil); D.R. Wills (Managing Director, W.D. & H.O. Wills, Australia).

about all contacts made, so that they in turn could inform other companies while maintaining an index of such contacts. Finally, the meeting endorsed the initiation of research on social and economic costs of smoking as useful, particularly as tar and nicotine deliveries were about to decrease. For the chairmen it seemed reassuring, though, that, according to the latest information on the link between nicotine and smoking behaviour, the feared theory that low tar would facilitate quitting could not be supported.[b] [394]

The Research Conference[c] in August 1981 (Pichlarn) focussed on technical issues.[d] It was recognised that, while additives would "assume increasing importance in product design", "the freedom to use them could become increasingly restricted".[124]

In September 1988, another BATCo meeting, the Research Policy Group Meeting[e] [98] taking place in Salzburg, focused on research questions and strategic issues. Apart from discussion of declining trends in markets and research questions, the issue of up-coming regulatory trends and requirements was addressed. It was felt that more efforts needed to be made to approach directly authorities such as the EEC, Governments and their Committees, in the way that RJ Reynolds or Philip Morris, who had been more successful until then, had done. The areas of product innovation and environmental tobacco smoke (ETS) were seen as obvious initial topics. The trends already emerging in anticipation of the proposed single European market in 1992 were already highlighted in that 1988 meeting. "The effect on our brands of decreasing tar delivery ceilings was strikingly demonstrated. It is also clear that Philip Morris is the company least affected by the planned changes".[98]

The 1990 Vienna Conference

The Sixth World Tobacco Exhibition and Symposium (Vienna Conference), held in Vienna from 22 to 25 October 1990, was organised by the industry journal *World Tobacco* and sponsored by the tobacco companies Austria Tabak, Philip Morris and RJ Reynolds. The main purpose of the exhibition was to sell machinery, mainly for cigarette production. 193 companies were among the exhibitors, representing 31 countries. According to the organisers, this exhibition was the largest and most comprehensive gathering of the tobacco industry worldwide. The symposium was part of this exhibition, and covered the three sets of relationships of the tobacco industry – European Community, Environment, and Eastern Europe, the last being the main topic. This was also the reason why Vienna, "the gateway to Eastern Europe", was selected as location for this event. At the time when the preparations for this conference started, the transition in Eastern Europe was not foreseen. As the director of the exhibition explained, "When we chose Vienna as the venue it was because of its traditional links with Eastern Europe

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[b] History this has proven to be right and it may be assumed that for many smokers the switch to 'low tar' or 'light' brands was an attractive alternative to give up smoking.

[c] Participants of this conference (held in Pichlarn from 24–28 August 1981) were: Dr. L.C.F. Blackman, Mr. R.M. Gibb, Mr. A.L. Heard, Mr. R.G. Nicholls, Mr. E. Rittershaus, Dr. R.A. Sanford, Dr. F. Seehofer, Dr. C.J.P. de Siqueira, Dr. C.I. Ayres, Dr. M.J. Hardwick.[124]

[d] The 15 working areas covered the issues of biological items, filters, tipping and paper, cigarette design, combustion, sidestream, smoke retention/human smoking, psychology and sensory testing, taste and flavour, leaf and biotechnology, tobacco processing, expanded tobacco, secondary automation, ventilated cigarette technology, and test method development. General issues were addressed in policy and strategy, in particular with regard to funding, project selection, role of technology, carbon monoxide, compensation, additives, communications on restrictions, and competitor intelligence.[124]

[e] Participants of this meeting were: Mr. A.L. Heard (BATCo); Dr. E. Rittershaus and Dr. E. Kausch (BAT Cigaretten Fabriken, Germany); Mr. M.L. Reynolds and Mr. T. Riehl (Brown and Williamson); Dr. P.J. Dunn (Imperial Tobacco); Mr. G. McGregor (WD & HO Wills); Dr. C.J.P. de Siqueira (Souza Cruz, Brazil); Dr. R. Binns (BATUKE, U.K.); Dr. R.E. Thornton (BATCo).[98]

and the thought that an international tobacco industry exhibition would help to encourage east-west trade. Little did we realise that history would be made in October 1989 and the full meaning of perestroika became evident. The timing of the World Tobacco Exhibition and Symposium is thus even more opportune".[395]

However, only 300 participants attended at this Vienna conference, presumably due to the dominance of American companies. Participation was clearly led by delegates from the sponsoring U.S. company Philip Morris, followed by the co-sponsors Austria Tabak and RJ Reynolds; in contrast, BAT, Gallaher, Reemtsma, Seita and Imperial Tobacco were represented by only a few delegates. Philip Morris' presence at the conference was most active; the company also assisted visitors from Eastern Europe to attend the exhibition.

It was recognised that Eastern Europe represented an enormous opportunity for the transnational tobacco companies (TTCs), with the declining consumption figures in the West. As published in the *Tobacco Reporter* of October 1990, Mr. Zimmel of *Austria Tabak* summarised the opportunities in Eastern Europe this way: "Investment in Eastern European markets is full of risks. However, the potential reward may overshadow the pitfall... Companies willing to become more active in former socialist countries must think in longer terms; quick return on investments is unlikely. But being active quite at the beginning of this period of transition offers plenty of opportunity".[395]

Austria Tabak was among the most active companies present in Eastern Europe before 1989, alongside Philip Morris, RJ Reynolds, BAT and Reemtsma. For example, the Eger Tobacco Factory in Hungary established a licence contract with Philip Morris in 1975 and with *Austria Tabak* in 1976. As reported in a special 1990 edition of the Hungarian Tobacco Journal on the Vienna conference, shortages of hard currency in Hungary were compensated easily: apart from "payment" for the licence fee in the form of Hungarian tobaccos and counter-trade, it became common for young experts from the Eger Factory to spend several months in the modern, sophisticated plants of the foreign partners, for example Linz (Austria Tabak) and a plant of Philip Morris in the United States.[395] Besides Hungary, *Austria Tabak* was also negotiating with Poland and Yugoslavia.

APPENDIX E

Self-portrayal of Austria Tabak (Gallaher)

In its overall concept, Gallaher sees itself as a "responsibly behaving, good corporate citizen", boasting of its success and its strong position on the stock market. On its homepage it says:

> "Every second of every day, almost four thousand people somewhere in the world light up a cigarette made by Gallaher. The company takes great pride in producing billions upon billions of quality products for those people who choose to smoke."[131]

The description of smokers as "those people who choose to smoke", i.e. as "informed adult smokers" is interesting. Issues surrounding smoking and health are met with a "demonstrated sense of responsibility and responsiveness", underpinning "the company's relationship both to those responsible for public health and to those who choose to smoke". As part of the responsibilities of a tobacco manufacturer in such an important position, a range of environmental, charitable, and corporate policies have been established, conducted with "appropriate sensitivity to the issues surrounding its products" and with a "demonstrated transparency of approach". To underline its supposed altruistic and benevolent activities, Gallaher "supports a wide range of charities without seeking public reward or recognition" – another expression for hidden sponsorship, one might say.

Although not party to the US court ruling on release of documents, Gallaher has voluntarily established a web site of its corporate archive[91] as a contribution to the smoking and health debate. This site did not, however, prove to be very helpful. Noteworthy is a lengthy submission on smoking and health, as presented to the UK Health Select Committee, which is published on Gallaher's corporate web site[92].

Gallaher is aware of the health risks associated with smoking, although the fact is immediately put into perspective by narrowing it down to "some smokers":

> "It must be clear to all that a real health risk exists. People who choose to smoke are more likely to contract certain diseases than those who do not smoke. Indeed, for many years, Gallaher has proceeded on the basis that some smokers are more likely to contract certain diseases, such as lung cancer, heart disease and certain other circulatory and respiratory diseases, than non-smokers."[131]

Although the need, the rights, and the responsibilities of governments for regulations regarding the manufacture, distribution and marketing of tobacco products are recognised, tobacco is seen as something unique, which in turn has to be addressed in a unique way, and regulation needs to be "balanced" – i.e. in the interest of the tobacco industry, of course.

> "Regulation does need to be balanced and demonstrably correct in the pursuit of public health policy objectives. Where regulation is appropriate, Gallaher will applaud initiatives and co-operate. Where regulation is inappropriate, Gallaher reserves the right to argue its case in a court of law or in the public arena, in an attempt to bring balance to the regulatory process."[131]

Gallaher further acknowledges that positive changes can be made to tobacco products by reducing the risks associated with smoking while recognising that there is no conclusive consensus about what is a safer cigarette. The company is pursuing a policy of lowering tar yields of its

cigarettes, as "no better course than tar reduction has been advocated by public health bodies to address the health concerns surrounding those who choose to smoke".[131]

A very interesting point is how Gallaher is dealing with the term "addiction", playing it down by arguing that, in "modern language" it has acquired a "wide interpretation", with smoking just being one of many addictions. In particular, it denies that smoking is addictive but rather a "habit", although possibly a "very strong habit".

> "Gallaher acknowledges that, in today's language, smoking is regarded as addictive. The meaning of addiction has developed over time and now is given such a wide interpretation that it encompasses a range of behaviours, including smoking. However, the company cautions against communicating health messages that suggest that, because smoking is regarded as addictive, it is impossible to give up. Gallaher believes that although smoking is a habit, and for some a very strong habit, people can give up smoking and do so."[131]

The company does not bother to mention that for many people "who choose to smoke" it is very difficult or impossible to quit the "habit" of smoking, and that, on the other hand, every addiction can in principle be overcome by appropriate support and willingness to do so.

Similarly, its statements regarding environmental tobacco smoke do not consider passive smoking as a health hazard to others; at worst, it might be "a source of considerable annoyance to non-smokers". In addition, it is clearly playing down the research evidence on its health effects, describing it as "based on weak and inconclusive science" and advocating more "common sense" instead.

> "Gallaher acknowledges that there are those in the public health community who believe that environmental tobacco smoke poses a health risk to non-smokers. But, whilst readily accepting that environmental tobacco smoke can be a source of considerable annoyance to non-smokers, the conclusions reached by those in the public health community appear to be based upon weak and inconclusive science. Nevertheless, given the concerns surrounding environmental tobacco smoke, Gallaher advocates an approach based on common sense and co-operation within a sensible smoking policy framework. In particular, because of specific concerns with respect to asthma and respiratory conditions, Gallaher urges that smokers show consideration to others with a sensitivity to these health conditions and, particularly, when in the presence of children."[131]

The company's position in relation to children and smoking is rather hypocritical. It believes that only "informed adults" should smoke and children should not smoke. It does not mention that most "informed adult" smokers took up smoking when they were adolescents, and that in adulthood, sometimes even before, it has become "a very strong habit". It also fails to mention that at least part of its advertising is clearly and deliberately targeted at youth.[396] Gallaher claims to have supported a number of initiatives over the years addressed at reducing the incidence of smoking by children, the most recent being a commitment to print the message 'For adult use only' (in Austria: *'Rauchen: Bitte nur Erwachsene'* = 'Smoking: Please adults only') on all packets of cigarettes. Given the fact that one reason why children and adolescents start smoking at an early age is to appear adult[60], this message sounds more like an invitation. Even after inquiring from the company which other initiatives would be supported, no palpable answers were given. Although presented as one of several initiatives, the use of printed requests to minors to kindly refrain from smoking would seem to be the only initiative by Gallaher to keep children away from smoking. In the past, however, *Austria Tabak* has also contributed to an Austrian youth campaign *(Chapter 8)*.

Gallaher puts a great deal of effort into stressing its responsible behaviour and its willingness to engage in a constructive dialogue in co-operation with governments. It claims as evidence of

this the "steps the company has taken to seek to reduce the risks associated with smoking". However, apart from reducing the tar yields in cigarettes, which has already been proven not to lead to any risk reduction, and the massive advertisement for "more" light cigarettes, no steps that would reduce any risks can be detected. Gallaher justifies this in its position statement on the World Health Organisation's Framework Convention on Tobacco Control rather elegantly:

> "So far as Gallaher is aware, no better course than tar reduction has been advocated by public health bodies to meet the health concerns surrounding those who choose to smoke."[133]

APPENDIX F

Measures to reduce the demand for and supply of tobacco products

The following sections explore in more detail the various measures that have been recognised to affect tobacco consumption.

Legal and regulatory measures

Legislation has certainly proven to be a key strategy, forming the cornerstone of every successful tobacco control programme. Ideally, it comprises the whole range of regulatory measures:

- Labelling: consumer information on contents of cigarettes
- Health warnings on cigarette packets
- Smoking bans and restrictions on smoking in workplaces and all public places (smoke-free environments), including restaurants and bars
- Bans on advertising, promotion and sponsorship
- Delivery and marketing of tobacco products
- Control of illicit trade (anti-smuggling measures)
- Age limits for smoking and purchase of tobacco products
- Legal action against tobacco companies
- Legal enforcement and sanctions for malfeasants

Since the first EU directives to control labelling and advertising were passed in 1989, national legislation can no longer be seen as an isolated matter for individual governments. Governments are required to enact European legislation into national law, with sanctions if they fail to. This, for example, was the case when Austria delayed one year in its introduction of clearly visible health warnings on cigarette packs and still used the terms 'light' and 'mild', including the name of one of its bestselling brands *Milde Sorte*. Although every EU member state has to implement the EU tobacco regulations, states are permitted, within limits, to adapt them to their own circumstances. In Austria, tobacco-related issues are regulated in its 1995 Tobacco Act, last amended in 2003. Smoking in the workplace is regulated in the Employees' Protection Act of 1994 (last amended in 2001), although this regulation is not fully adhered to and does not include all employees (for example, employees in the hospitality industry are excluded). Details of the various laws and regulations are given in Chapter 8.

The industry's response

The industry's point of view, of course, is different. Judging from the vehemence it argues in particular against advertising bans, smoking bans in public places and altogether anti-smoking legislation, one can gather the importance and effectiveness of these measures.

In a confidential report on PR activities with regard to smoking and health, a Philip Morris document dated already in 1975 reveals the fears of the industry: "the discussion about a possible smoking prohibition at work places is especially dangerous as the sales would be severely

affected through such a measure".[100] The necessity of continued advertising and continued opposition to legislation on both EU and national level have already been discussed earlier. The present situation in Austria with a very cautiously starting discussion on legal enforcement of smoking bans in public places is an excellent example for a decade-long misleading of the public, i.e. the successful socialisation of the public towards a pro-smoking climate, and the equally long close collaboration between the Austrian tobacco industry and health politicians, government consultants, and scientists *(Chapter 9)*.

Taxation and fiscal measures

In the first half of the 19th century, after attempts at banning smoking in several countries failed, taxation was introduced as a measure to control tobacco consumption. This very soon turned out to be "such an important source of revenue that in 1851 Cardinal Antonelli, Secretary to the Papal States, issued an order that the dissemination of anti-tobacco literature would be punished by imprisonment".[209]

Today, while tax revenues from the trade in tobacco products are still an important income source for governments, international evidence suggests that price and tax increases are also one of the most effective components of a comprehensive national tobacco control policy[397]. The WHO recommends that effective policies should include, first, taxation, followed sequentially by comprehensive bans on advertising and activities to disseminate information on the health risks of tobacco.[398]

Some finance ministries fear raising taxes, influenced by the industry's arguments that higher taxes would lead to a loss of revenue and an increase of smuggling, in addition of being unfair to the poor. However, it has been repeatedly shown that a continuous rise of the unit price of tobacco products (in particular cigarettes) not only reduces consumption and smoking prevalence, particularly among young people, but also increases government revenues from taxes because consumption usually falls at a lower rate than the percentage increase in price[398] *(see figures for Austria in Chapter 8)*. According to the World Bank and others, a price rise of 10% on a pack of cigarettes would be expected to reduce consumption by an average of about 4% and increase revenues by about 7%.[3 132 198 399-401] In particular children and adolescents, who are more responsive to price rises than adults, and individuals with a very low income seem to be most effected by this measure. [3 198 401 402] According to Jha & Chaloupka, "increasing taxes on tobacco is likely to be the most effective way to deter children from taking up smoking and to encourage those who already smoke to reduce their consumption".[401] However, as addicted consumers respond relatively slowly to price hikes the proportionate reduction in demand does not match the proportionate size of the tax increase.[401] The third argument, targeting the welfare of smokers, has been countered by Jha and colleagues insofar that, while the poor are certainly more price-responsive than the non-poor, this assumes that they will all continue to smoke, while many will smoke less or give up smoking entirely. In addition, the poor are less responsive to educational measures (i.e. they are difficult to reach). And finally, this argument should take into account the entire tax burden when considering the impact on the poorer part of the population, not only the small share of taxation from tobacco. Last but not least, the overall health benefits have to be considered. As smoking accounts for much of the gap between rich and poor, the poor, so Jha and colleagues argue, would benefit most from price rises.[3 198 399 401 402]

Another frequently raised concern is that higher taxes would lead to a massive increase in smuggling, thereby keeping cigarette consumption high but reducing government revenues. However, while smuggling is a serious problem, tax increases will still bring greater revenues and reduce consumption. Therefore, rather than forgoing tax increases and health gains, the appropriate response would be to crack down on criminal activity, activity in which it is increasingly clear that some tobacco companies are complicit.[400 401]

Consequently, apart from maintaining high taxes on tobacco products and even continuing to raise them above the rate of inflation or growth in income, to ensure that they become less affordable, other strategic actions at the national level should include the prohibition of all tax-free and duty-free sales of tobacco products, the tackling of smuggling, the allocation of a significant part of tobacco taxes for the funding of national tobacco control programmes, and the harmonisation of taxation and prices of all tobacco products so that substitution of one tobacco product by another does not occur. Within the European Union, some level of harmonisation of taxes has already been achieved.[132]

As summarised by Prabhat Jha, the appropriate tax level for tobacco products is dependent on the degree to which society wishes to protect children (and non-smokers in general), on health care costs attributable to smoking, and on desired tax revenues.

The industry's response

In accordance with all other tobacco companies who, of course, want to keep their products cheap and affordable to all, *Austria Tabak* (now Gallaher) is also demanding "fair levels" of taxes on tobacco products, reasoning that "smokers should not be punished financially for the pleasure of being smokers", underpinning the assumption that smokers are "informed adults" and fully aware of the health risks associated with smoking. And, in relation to duty-free sales of tobacco products, Gallaher believes that "there is no rationale whatsoever to justify a ban"; they are "highly regulated by all countries to minimise any illicit trade". The company argues that "any ban on duty free would harm the regulated duty free retail industry but have little, if any, impact on total sales of tobacco. These sales would simply move from a duty free environment into a domestic one".[133]

In February 2000, as the Austrian Finance Minister Karl-Heinz Grasser proposed a tax rise to raise an additional €87 million, *Austria Tabak* Chief Executive Heinz Schiendl said it would "discourage smokers at home", i.e. in Austria, leading them to buy their cigarettes in Germany and Italy. Yet Jan Berger from *Constantia Privatbank AG*, said: "Some Austrians will also use it as an excuse to stop smoking."[403]

Already in a 1983 industry document (INFOTAB board of directors meeting in Bath) one can read that taxation, being a serious threat, was to be given high priority and ways of industry actions were discussed. "It was agreed that a main influence on governments was consumer protest against tax rises. Mr. A. Reid commented on TAC's taxation campaign, as an example of action carried out by industry."[105]

Environmental tobacco smoke (passive smoking)

Environmental tobacco smoke (ETS) is a major source of indoor air pollution, and the greatest source of population exposure to respirable particulate air pollution (RSP).[404] The accumulation of evidence on the health consequences of involuntary exposure to ETS therefore emphasizes the need for stronger regulation to protect non-smokers, particularly children, and reduce the average consumption of tobacco and smoking prevalence in the population. In addition, regulation also contributes to the altering of the social perception of a behaviour that was once accepted, leading to the de-glamorising of smoking.[132] Population polls like the 1995 survey of 18,500 EU citizens in all 15 member states found strong public support for regulation, not only from non-smokers but also from the majority of smokers.[405]

Therefore, enforcing national legislation and increasing compliance through comprehensive information campaigns and litigation are seen as crucial elements for effective tobacco control policies. In particular, the WHO recommends the following strategic national actions:[132]

- introducing or strengthening legislation to make all public places smoke-free, including public transport and workplaces;
- banning smoking indoors and outdoors in all educational institutions and their premises for children up to the age of 18 years, and indoors in all other educational institutions;
- banning smoking in all places of health care delivery and their indoor and outdoor premises;
- banning smoking at all public events arranged indoors and outdoors;
- banning or severely restricting smoking in restaurants and bars, to protect owners, employees and clients from serious health damage;
- classifying environmental tobacco smoke as a carcinogen to protect the right of workers (non-smokers and smokers), particularly those working in smoking environments, and to speed up the banning of smoking at all workplaces.

The industry's response

Gallaher's response to the issue of ETS and protection from passive smoking still focuses on "weak and inconclusive science" and "advocates an approach based on common sense and co-operation within a sensible smoking policy framework".[133] Gallaher's position on this subject has already been described in more detail in APPENDIX E.

Tobacco advertising, promotion and sponsorship

Restrictions on tobacco advertising and sponsorship have proved to be effective elements of tobacco control programmes worldwide.[176] Empirical evidence shows that a fully comprehensive ban on advertising, covering all media and all forms of direct and indirect advertising, contributes to the reduction of tobacco consumption and lessens the social desirability of smoking, in particular among young people. Along with the promotion of a smoke-free environment, regulation of advertising contributes to making non-smoking the accepted norm. According to the World Bank, such comprehensive bans can reduce the consumption of tobacco products by around 7%.[132]

Therefore, as recommended by the WHO, the strategic national actions should include:[132]

- prohibiting of all forms of direct and indirect advertising for tobacco products and smoking, including promotion, "brand-stretching" and sponsorship;
- adopting national measures and imposing appropriate regulatory restrictions to ensure that tobacco advertising, promotion and sponsorship do not promote a tobacco product by any means that are false, misleading or deceptive or that are likely to create an erroneous impression about its characteristics, health effects, hazards or emissions.

Of course, advertising being so advantageous to tobacco companies, the industry has developed ways to circumvent advertising bans. According to Luk Joossens there are at present three classical tobacco advertising loopholes: Formula One and the *Fédération Internationale de l'Automobile (FIA)* [a] [b]; Directive 2003/33/EC, which does not include indirect advertising and is presently challenged by the German government; and, most important especially for the young clientele, the internet, which is popular amongst youngsters, and as yet without any legislative control.[407]

Although the tobacco industry is keen to stress its commitment and sense of responsibility, exercising "special care to ensure its consumer advertising is directed at adult smokers"[131], the effects of tobacco advertising are clearly demonstrated. A recent review by Gerard Hastings and Lynn MacFadyen, in the form of a qualitative analysis of internal papers of five UK advertising agencies with clients in the tobacco industry, revealed the following insights to their four key questions:[406]

- Tobacco advertising is intended to increase consumption as well as brand switching among current smokers and has a powerful effect on young people (assisting recruitment). In particular the use of imagery and positive associations in tobacco advertising has a notable impact on young people. Children are also very brand conscious and, compared with adults, are much more likely to smoke the most popular and well advertised products.
- Sponsorship and advertising work in exactly the same way and are only a small part of tobacco marketing. Like advertising, sponsorship is meant to increase brand awareness, promote strong brand associations, and ease the decision to take up smoking.
- Tobacco advertisers are driven by a commercial imperative to increase sales, and they show no concern for the ethical or public health consequences of their actions.
- Voluntary agreements simply do not work and must be replaced by statutory measures.

It may be assumed that these results are also valid for Austria. The first point was confirmed by one of the advertising agencies which has a contract with *Austria Tabak*. The last point has been addressed by the Austrian Tobacco Law of 1995, which includes a partial advertising ban.

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[a] A preference for Formula One racing sponsored by cigarette manufacturers was found to be a significant independent variable in progression to regular smoking.[406]

[b] Every year, the tobacco industry spends 350 million euro in Formula One. FIA president Max Mosley announced a worldwide tobacco advertising ban in motoring sports in 1998, if there would be found any prove that there is a direct relationship between tobacco advertising and smoking.[299]

The industry's response

While recognising the role of Government in regulating the marketing of tobacco products, Gallaher maintains that "advertising is not designed to start people smoking, but rather to persuade smokers to switch from competitor brands, enabling a gain in market share, and to inform smokers of new initiatives in product development". Regulation, however, "needs to be balanced". The main argument is that the company "advertises its products to compete for market share". With regard to sponsorship, Gallaher does not believe that "people start smoking as a result of its sponsorship of events". It prides itself that special care is taken to ensure that its sponsorship activities are directed wholly or mainly at adults.[133]

Anti-smoking campaigns and other educational measures (information, training and public awareness)

As with the previously noted measures on taxation, ETS, and advertising, continuous and intensive information and education programmes have proved to be effective instruments for tobacco control. Prior to the introduction of tobacco control measures, however, training for health professionals and intensive public information and debate are important to prevent those measures being undermined by misleading tactics by the tobacco industry. Strategic national actions should therefore include:[132]

- developing and implementing effective and appropriate basic curricula and training programmes on tobacco control for policy-makers, health professionals, students, educators, and other relevant persons;
- facilitating and strengthening education, training and public awareness campaigns, including counter-advertising;
- ensuring that the general public, and notably children, young people and vulnerable groups, are fully informed about the health risks, addictiveness and social costs of tobacco consumption and exposure to tobacco smoke, and about the benefits of smoking cessation and tobacco-free lifestyles;
- endeavouring to promote the participation of public agencies, non-governmental organisations (NGOs) and civil society in the development of strategies for tobacco control; proper links between the efforts of NGOs and health professionals should be ensured.

These, however, should be seen as a reinforcement of other tobacco control measures; they are seldom effective on their own. "Special attention should also be paid to not involving the tobacco industry in information campaigns, particularly those targeting young people"[132] – advice that the Austrian government could usefully heed.

The industry's response

Gallaher contends that it "supports sensible measures to raise awareness of the health risks associated with smoking" and points at its "voluntarily published communication on this, and other key issues ..... entitled 'An International Company Behaving Responsibly'", available on its homepage. It also mentions the voluntarily placement of more than 500,000 documents "deemed by external lawyers possibly to be smoking and health related" from its corporate

archive on an electronic document warehouse in 2000.[133] The general statement of the company as to non-price measures to reduce the demand for tobacco relates to the willingness and preparedness to work with national and international bodies:

> "Gallaher is fully committed and prepared to work with national authorities in developing standards and policies to raise awareness of the health risks associated with smoking. Where countries operate within a 'trade zone', such as the European Union, the Company believes that a harmonised approach, which achieves uniformity, is in the interests of all."[133]

Therapeutic measures, smoking cessation

Social attitudes, legislation, and public health measures influence changes in smoking behaviour.[376] In particular, following the onset of comprehensive anti-smoking campaigns, many smokers want to give up smoking. Some of them accomplish this without clinical intervention, some try one method successfully or make continuous attempts, and some make multiple attempts to quit by trying different methods. However, as individuals and preferences differ, most smokers will benefit from the availability of a range of aids to help them.[408] Particularly women would prefer a wider offer of alternative "soft" cessation methods.

Methods that claim to help smokers to quit can be categorised as those involving provision of information and support, those involving pharmacological preparations, and those using psychological methods, although all three are complementary. The first include brief advice from health professionals; information centres of local health authorities, local health promotion associations, or NGOs (individual or group counselling); telephone support (quitlines); self-help or other support groups; cessation courses or programmes lasting several weeks; information brochures and self-help materials. Pharmacological interventions include nicotine replacement therapy (such as chewing gums, transdermal patches, inhalers, nasal sprays, sublingual tablets, and lozenges) and other pharmacological interventions (bupropion, nortriptyline, clonidine, anxiolytics, lobeline, mecamylamine). Psychological interventions include aversion therapy, acupuncture, and hypnotherapy.

A review by the Cochrane Tobacco Addiction Review Group[408] summarised evidence for the effectiveness of most of these available interventions and came to the following conclusions:

- Advice from doctors, structured interventions, and individual and group counselling are effective interventions.
- Generic and self-help materials are no better than brief advice but more effective than doing nothing; personalised materials are more effective than standard materials.
- All forms of nicotine replacement therapy are effective.
- The antidepressants bupropion and nortriptyline increased quit rates in a small number of trials; the usefulness of the antihypertensive drug clonidine is limited by side effects.
- Anxiolytics and lobeline are ineffective.
- The effectiveness of aversion therapy, mecamylamine, acupuncture, hypnotherapy, and exercise is uncertain.

Information on smoking cessation and specific cessation programmes tailored to the needs of those willing to quit are an important component of policies to reduce smoking prevalence. The WHO recommends:[132]

- implementing age- and gender-based promotional and educational programmes aimed at encouraging cessation of tobacco use;
- elaborating and integrating best practices in treatment of tobacco dependence and prevention of relapse (i.e. behavioural support, counselling services, "quit lines", and routine advice) into national health programmes, plans and strategies;
- establishing and strengthening programmes of training in smoking cessation techniques for health professionals, including physicians, nurses, dentists, and pharmacists, as well as teachers, and community and social workers;
- establishing, in health care facilities, programmes for diagnosis, medical advice and treatment of tobacco dependence, with a priority focus on primary health care.

Both training and cessation services should be adequately funded, and mechanisms to increase the affordability of treatment for low-income smokers are necessary.[132]

There is now considerable evidence that, no matter at what age, smoking cessation has benefits, with Peto stating that "Even in middle age, smokers who stop before they have developed some serious disease avoid MOST of their subsequent risk of death from tobacco: smokers who stop before middle age avoid almost all their risk.".[5] Smokers who quit before the age of 50 halve their risk of dying in the next 15 years.[263]

According to the Report of the Surgeon General on Women and Smoking[206], particular attention should be paid to smoking cessation in women, who are more likely to quit smoking than men, particularly during pregnancy, and whose smoking places at risk both their own health and the health of their offspring. As noted above, women would particularly benefit from a wider range in the offer of cessation techniques.

Consequently, national or regional implementation of moderately priced, group-specific and effective smoking cessation interventions would not only increase smoking cessation rates, but would more than pay for themselves through increased health benefits within 3 to 4 years.[4]

The industry's response

As already described in APPENDIX E, Gallaher has some problems with the term "addiction", which it would rather replace with the term "habit". It has particular concern about those who want to stop smoking being categorised as addicts.

> "For most, smoking is best considered a habit and, while for some it can be a very strong habit, people can and do give up smoking. The best explanation Gallaher can provide for what it understands is meant by addiction in a tobacco context, is that smoking can be a repetitive course of conduct that, for some smokers, may be difficult to stop, even though there are well known risks associated with that behaviour. The problem with the word 'addiction' is that its meaning has changed over time. In terms of any message public health authorities may wish to give smokers, it could be unhelpful to those who want to stop smoking to categorise it as an addiction.".[133]

Product control and consumer information

To reduce the risks posed by the carcinogens and toxic elements of cigarette smoke and other tobacco products, more accurate assessment of their nature, stronger regulation of these substances, and adequate consumer information are all needed. Therefore, the WHO recommends the following national actions, leading ultimately to agreed international standards:[132]

- adopting standards for the regulation of tobacco products, including standards for testing and measuring, etc.;
- introducing and enforcing measures for tobacco product disclosure by all manufacturers, including details of major ingredients and additives, major constituents of tobacco smoke, as well as of their toxicity, carcinogenicity and addictiveness, and promoting the availability of clear and meaningful information to the public;
- banning the terms "low tar", "light", "ultra light", "mild" or any other misleading term;
- ensuring that each unit, packet or package of tobacco products carries a strong health warning, in accordance with international agreements.

The industry's response

While recognising the role of governments to regulate the manufacture of tobacco products, Gallaher points to its efforts in lowering tar and nicotine yields and its good citizenship.

> "Gallaher has for many years successfully pursued a policy of lowering relative tar and nicotine yields, a policy which continues today. To date, as far as Gallaher is aware, no better course, other than tar reduction, has been advocated by public health authorities to address concerns surrounding those who choose to smoke.
>
> "Gallaher abides by two key principles: not to use any ingredients that do not comply with country regulations and not to use any ingredient that Gallaher believes would add to the health risk associated with smoking."[133]

Since 2002, a list of all products of combustion from all brands of the Gallaher Group in all countries of distribution, has been provided on the company's website.

Health warnings on packs "should be proportionate and should respect trademark rights". With relation to the terms 'light', 'mild', etc., the company points to the "real" meaning of these descriptors:

> "The use of descriptors on packs is designed to enable consumers to make an informed choice between different brands. Descriptors such as 'mild', 'lights', and 'ultra' indicate to consumers a means of reflecting different relative nicotine and tar smoke-yield deliveries as measured using ISO standard measurement techniques. This information is not, and never has been, intended to suggest that one brand is less hazardous than another."[133]

Control of illicit trade (smuggling)

Smuggling must be differentiated from bootlegging, which describes the trafficking of relatively small amounts of tobacco products by individuals. There is now growing evidence that major tobacco companies are complicit in smuggling, involving the movement of large quantities of tobacco products (typically container-size loads) on which duty has not been paid.

Smuggling is contrary to the interests of public health and the state, which is deprived of tax revenues. In addition, it supports criminal organisations and corruption. Unless smuggling is counteracted at both national and international levels, the impact of other tobacco control measures may be undermined. Therefore, the WHO recommends the following strategic national actions:[132]

- marking of all packages of tobacco products sold or manufactured to allow them to be tracked and traced;
- monitoring and collecting data on cross-border trade in tobacco products, including illicit trade, with exchange of information;
- enacting and/or strengthening relevant legislation and penalties.

The industry's response

Gallaher's public position is that smuggling is closely related to high taxation, and so not in its interest.

> "Gallaher deplores smuggling as it undermines the legitimate market for the Company's products. It therefore operates an international trade policy in respect of its sales aimed at ensuring that, as far as possible, the Company's products are smoked in the intended destination market."[133]

Youth access

International experience shows that age restrictions on the sale of tobacco products are difficult to enforce and altogether not very effective. The setting of age limits should therefore be only part of a comprehensive package of measures.[132] Strict surveillance and sanctions would be necessary to succeed, but even after effective education of distributors, surveillance would be an enormous, difficult and very expensive task – and teenagers would still have access to cigarettes (especially where vending machines are operated, like in Austria). In addition, both youth and obliging adults would be criminalised. Besides, in a society where smoking by over 16 year olds is highly tolerated and seen neither as an offence nor as a health hazard to both smokers and those in their environment, regardless of age, it is difficult to argue why under 16 year olds must not smoke. Therefore, the most promising measure to reduce smoking among teenagers appears to be to reduce environments where smoking is tolerated or even encouraged and to change social norms within a society. The setting of age limits for smoking in teenagers is only important insofar as it allows parents as well as the owners or administrators of premises such as schools or bars to prohibit smoking.[130 409]

Although experts in the field of public health agree on the importance of preventing children and young people from starting to smoke, experts differ when it comes to the subject of youth access and its regulation. While the WHO recommends strict regulation, including setting age limits, requiring evidence for having reached this age, licensing of retailers, and banning all forms of unlicensed sales, Stanton Glantz judges this regulated approach a failure. At his presentation at the 2003 World Conference on Tobacco or Health he demonstrated that sales restrictions do not decrease smoking rates among youth. In addition, there is evidence that the tobacco industry has used youth access as a focus for a grass-roots network to lobby against effective tobacco control policies (such as clean indoor air laws). According to Glantz, one simple, but very effective measure to reduce youth smoking would be to stop smoking in the movies pro-

duced by the film industry. There is now strong evidence that there has been an increase in smoking in films and a dose-response relationship between exposure to smoking in movies and smoking rates among children and young people.[410-412] In addition, there is well-founded concern that both film makers and actors are receiving considerable "incentives" from the industry which views this as an effective loophole to get round the advertising ban on smoking.[410 412 413] There is, for example, a 1983 letter from Sylvester Stallone to Associated Film Promotion regarding the payment from Brown & Williamson of $500,000 for the use of its products in no less than five feature films[414], or the answer of Philip Morris U.S.A. in 1989 to the inquiry of a Congress member about the industry's "sponsoring" of films in the form of product placement fees[415], a practice which, of course, is widely used not only by the tobacco industry.

Although Philip Morris denies seeking to influence producers or script writers to include scenes in which "smoking or related products were to be depicted", shifting the blame to filmmakers who would approach the company themselves with their film scripts, it admits employing "independent film industry consultants" to review the approximately 150 film scripts submitted yearly to Philip Morris and to "advise" the company. However, between 1979 and 1989, Philip Morris has "provided products or signage for an average of 17 films per year" and, in an inquiry conducted in response to allegations about this activity, it indeed "discovered" the payment of product placement fees, but only for foreign films and on only two occasions. One was the movie Superman II, where Philip Morris "offered" to pay £20,000 in 1979 to the English Studio Dovemead Ltd. for Marlboro brand exposure; the other was the payment of a Tokyo advertisement agency for Philip Morris in Japan to a Swiss company in 1988 to include the exposure of a Lark cigarette pack (a brand sold in Japan "where the James Bond character is especially popular") in a new James Bond film, entitled "Licence Revoked". Another reference was made to a $5,000 contribution to the Sylvester Stallone Fund for Autism in 1985, "made at the suggestion of Mr. Stallone". The letter from Philip Morris finishes by pointing to the dangers of "unwarranted regulation" and "government intrusion into artistic decisions", referring to smoking as an "integral part of American art."[415]

> "Finally, I would like to emphasize our belief that the ability of an artist to portray smoking in film or any other media is an important right deserving protection from unwarranted regulation. Government intrusion into artistic decisions which determine whether and how smoking or any other lifestyle actively is to be portrayed is extremely dangerous. Smoking is an integral part of the lives of millions of Americans. It is only natural that it is also an integral part of American art."[415]

Returning to the discussion on youth access, there is more or less consensus on the banning of sales through vending machines (from the industry so-called "silent salesmen"[77]), self-service displays, and other unlicensed forms of distribution. As Gerard Dubois has noted, nicotine is the only freely available addictive substance that, if used as intended by those selling, kills half of its users. He calls smoking a paediatric disease, so cigarettes should not be sold to minors.[416]

There have been important developments in the industry's approach to youth smoking over recent years. They have funded so-called "youth anti-smoking campaigns" and presented new "corporate ethics" schemes with an ostentatious awareness of "corporate responsibility". However, these are mostly seen as cynical public relations tricks which make effective public health policy even more difficult to achieve, as some responsible opinion leaders are being fooled by these new tactics.[62] Regrettably, Austria's decision-makers and some of their consultants are among those fooled (consciously or unconsciously).

The industry's response

Gallaher "fully supports any measure designed to make smoking less attractive to children". As already described in APPENDIX E, Gallaher believes "that only informed adults should smoke and that children should not smoke". It points to its most recent initiative "aimed at reducing the incidence of smoking by children", namely the addition of the label "For Adult Use Only" on every pack of cigarettes and hand rolling tobacco. It even prides itself in "participation in the funding of organisations whose role is designed to highlight the dangers of smoking to children", as, for example, the Rodin Foundation in Belgium. Less clear is the company's statement on cigarette vending machines:

> "Gallaher believes that access to cigarette vending machines should be strictly controlled to prevent sales to children. Gallaher does not, however, support the prohibition of vending machines, which would prevent legitimate access by adult smokers. Instead, Gallaher proposes that vending operators and manufacturers identify and utilise systems that enable the purchase of tobacco products by adults only."[133]

APPENDIX G

This presentation of successful interventions and strategies in various countries is divided in examples from European countries, which are considered to serve as a better example for Austria, and examples from overseas countries, which are needed for describing the broader international experience and the lessons learned.

Reducing smoking: National strategies in selected European countries

This section will deal with those western European countries that are at the cutting edge in tobacco control, featuring the most successful characteristic of each country. In particular the Scandinavian countries Sweden, Norway and Finland are outstanding within Europe in their sustained tobacco control policies, having begun their efforts to reduce tobacco consumption decades ago. In these countries, non-smoking has become a socially accepted cultural norm, and a smoke-free environment is part of the notion of a healthy environment. To some degree, smoking in northern European countries is now established as a sign of social exclusion and deprivation.

Norway

Norway's restrictive national tobacco control legislation has attracted much international interest for many years. While striving for a comprehensive tobacco control plan, restrictive measures, in particular the total ban on tobacco advertising since 1975, represented Norway's greatest success.[138] Recent developments in tobacco control have been facilitated by courageous ministers, influential health prevention workers, NGOs and other organisations. After having seen the results, most people in Norway now seem to support the restrictions (according to national surveys).[137]

Already in the 1950s, Norwegian scientists became involved in studies on the health consequences of smoking, and in January 1964, simultaneously with the U.S. Surgeon General's Report, the Norwegian Chief Medical Officer released a report on "Cigarette Smoking and Health", with recommendations for a public health programme to tackle the problem. As a result of extensive media coverage, the smoking control issue was raised in the Norwegian Parliament only one month later, leading to a unanimous resolution to establish a Committee whose main task was to plan campaigns against cigarette smoking. As long ago as 1967, the Committee released a comprehensive report on "Influencing Smoking Behaviour" which was translated into English by the International Union Against Cancer in 1969. Discussions about an advertising ban were already initiated at that time by the Committee, and even before that by small, but strong pressure groups. It is reported that the months prior to the general elections of 1969 were most important in the history of the Norwegian tobacco advertising ban.[138]

In this way, one can say that Norway took a pioneering role in banning advertising totally, setting age limits for the sale of tobacco products and making health warnings compulsory – far ahead of most other European countries and of EU legislation. The 1972 Tobacco Act, entering into force in 1975, included a total ban on tobacco advertisement and promotion, including all indirect advertising. The ban attracted much attention abroad, both from organisations representing health interests, from other governments, and not least from the tobacco industry. Following attempts of the tobacco industry to circumvent this ban, the government introduced

amendments to the Tobacco Act, which were enacted in 1996. The Norwegian experience with the ban was considered in analyses carried out in Great Britain, New Zealand and the European Union as well as by the World Bank, all concluding that the ban had positive effects.[137]

Although less notable at the time, the 1972 Tobacco Act also included provisions banning the sale or procurement of tobacco products to children and adolescents under 16, and compulsory health warnings, which were at the time at the cutting edge internationally. Sweden soon developed a new concept of rotating warning texts on packages, a policy introduced in Norway in 1984.

As early as 1988, reacting to increased awareness of the adverse health effects of passive smoking, an amendment to the Tobacco Act ensured smoke-free indoor environments in public areas and means of transportation as well as in workplaces. The provisions were far-reaching, but excluded restaurants and bars. For these public areas the regulations stipulated that smoking may be allowed in 2/3 of the premises from 1993 and in 50% of the premises from 1998 onwards. In 1996, schools for pupils up to 15 years were made entirely smoke-free, indoors and outdoors.[137]

In November 2002, the government proposed an amendment mandating smoke-free restaurants, pubs and bars. On 8 April 2003, the bill passed by an overwhelming majority and will enter into force from 1 June 2004.[137]

Another focus of the comprehensive tobacco control plan is support for cessation. A quitline, established in 1996, proved a very successful tool and is free of charge. "During its first years it was merely a service where people called in and sought advice or information. The quitline then went from a passive to an active approach. Smokers who are ready to set a date for quitting can now be phoned back at regular intervals over the period of a year. Cooperation and exchange of information with other quitliners, mainly in Europe, have been essential".[137] In addition, in order to establish routines and predictability for cessation courses, "Week 3 and 36" as regular weeks for starting six-week cessation courses have been established. In the course of 2002 alone, more than 200 leaders for smoking cessation courses were trained by health authorities.[137]

Other tools in the tobacco control plan are prevention programmes in schools, community-based tobacco control strategies, information and education. Thus, after a series of ever tighter revisions, the Tobacco Act is today comprehensive. The commitment of the Norwegian government to tobacco control is evident. In February 2002, the Norwegian Minister of Health set an ambitious goal of halving the proportion of young smokers within five years.[137] In addition, Norway was the first country to ratify the FCTC.

Finland

Finland's history of efforts to reduce tobacco consumption has also been sustained over a long period, with nearly 30 years of experience of comprehensive tobacco control. In the 1920s, Finnish cigarette consumption was the highest in the world, far more than in other Nordic countries, while current figures are among the lowest in Europe.[135 139]

Following early publications of pioneering studies on the health hazards of smoking in Britain and elsewhere in the 1950s, organisations in Finland began to call for smoking reduction measures. In 1961, the Finnish Parliament unanimously urged the Government to adopt strong measures to reduce smoking. Although it took 15 years before the Act on Measures for the Restric-

tion of Tobacco-smoking was passed unanimously by Parliament in 1976, this comprehensive Tobacco Act turned out to be very progressive, including a total advertising ban, prohibition of the sale of tobacco products to minors, and making public premises and public transport smoke-free.[135 136]

The increasing volume of research on the effects of passive smoking on lung cancer, coronary heart disease and chronic obstructive pulmonary disease in the 1980s created greater awareness of the health hazards of second-hand smoke and eventually led, in 1995, to the drafting of new legislation. In 2000, environmental tobacco smoke (ETS) was included in a national list of carcinogenic substances. By doing so, Finland was the first country in Europe to legislate on ETS as a carcinogen. It also included the stipulation that restaurants must provide smoke-free areas.[139]

The Finnish strategy to reduce tobacco consumption is comprehensive, based on four main approaches: health promotion (information campaigns and public health programmes), pricing policy, legislation and research. Growing awareness about health issues, a continuous and lively public debate on tobacco control policies and the reasoning behind decision-making on the health hazards of environmental tobacco smoke, as well as a special strategy to tackle smoking among adolescents are important features of Finnish tobacco control policies. The Finnish example supports the evidence that a package of synergistic measures, particularly if they consist of long-term, comprehensive and mutually reinforcing policy elements, is more effective in reducing smoking than campaigns or any other single measure.[137] It also shows clearly that legislation is more efficient in reducing ETS and cigarette consumption than voluntary smoking restrictions.[139]

Among the key elements in this successful tobacco policy is the traditional collaboration between the health authorities and non-governmental organisations (NGOs), which in Finland have a long tradition of working together to reduce smoking[a], linked to intensive health promotion. In addition, the strong public support for tobacco control contributes fundamentally to the success of all these measures.[b]

In summary, the comprehensive tobacco control plan in Finland encompasses a total ban of tobacco advertising and sales promotion (since 1978); visible health warnings; a sales ban on tobacco products to people under 18 years old; a sales ban on oral snuff; smoke-free environments, including workplaces; legal classification of ETS as a carcinogen; state funds allocated for tobacco control; guidance on implementation and other smoking reduction measures; existence of a special agency for supervision; sanctions; product control; continuous monitoring and research.[137 139]

Presently, all indoor premises, except restaurants and private homes, are fully smoke-free, and smokers are reported to support this. In Finland, a smoke-free environment is not only an essential part of the notion of a healthy environment, but has also become an accepted cultural norm. Since 1995, when legislation made all workplaces smoke-free, public opinion has strongly backed non-smoking and smoke-free environments.[c] There is evidence that, since the introduc-

[a] As explained in a publication of the Nordic Council of Ministers, Finnish NGOs "have a key role in forming networks between public and local actors, citizens, politicians and any players interested in supporting and promoting health. During the last 20 years, there have been several common cessation campaigns, information activities, and efforts to strengthen local cooperation. As important opinion leaders, NGOs play also an active role in supporting legislative measures".[137]

[b] According to a 2002 opinion survey, 65% of the Finns approved of efforts to reduce smoking.[137]

[c] According to a national survey in 2002, 93% of the respondents were satisfied with smoking arrangements in their workplace.[137]

tion of these regulations, daily cigarette consumption and daily smoking prevalence have been declining significantly.[137]

Unlike the situation in most other countries, and particularly in Austria, where smoking is the social norm and non-smoking areas (or in most cases more correct: non-smoking corners or small sections at the edge of the dominant smoking areas) are the exception, smoking in Finland, where allowed, must be organised in specially constructed rooms, from where smoke cannot spread to smoke-free areas. If smoking is allowed outdoors, tobacco smoke must not be able to spread indoors. It has been recognised that effective guidance, supervision and the threat of sanctions are necessary to enforce legislative measures.[137]

Most tobacco control is financed from the state budget, using a proportion of the annual revenue from tobacco taxes (in 2003: 0.75 percent, equivalent to €4.5 million). Health authorities are responsible for the enforcement of legislative measures.[137 139]

For the tobacco industry, Finland is seen as a test case for how it can cope with restrictive tobacco legislation and how it can work around it. The obstacle facing tobacco firms is that the health-oriented tobacco policy enjoys widespread support in Finland and parliament has been a strong promoter of tobacco control policies and measures. The public debate focuses on the health hazards of smoking, and the industry cannot win the debate using health-based arguments.[137]

Sweden

Sweden was among the first countries in the world to fund tobacco control efforts. Since 1964, the country has also been developing a comprehensive step-by-step programme. Tobacco control activities began in the 1950s, but it was the late 1980s and early 1990s that saw a radical change in strategy. In 1990, proposals for a Tobacco Act (introduced in 1993) were published, followed by an intense campaign lasting over a decade and including activities in support of the ban on indirect advertising and promotion introduced in 2002. Also in 2002, national funding for tobacco control measures increased threefold for the period to 2004. Reinforcing the experiences of other countries over the last two decades, this campaign highlighted the need for a "concerted action by many people and organisations" at many levels, both non-governmental and governmental, including "the education of the general public and of health professionals, lobbying by youth organisations, high profile media events, legislation and increases in taxes".[137]

Decreases in both male and female smoking rates and stagnation in youth smoking after decades of decrease are among the key trends. Sweden traditionally hits the record with the lowest smoking rate (18%) in Europe. However, although Sweden claims to be the only country in the WHO European region that reached the Health for All target for smoking by 2000, with 80% non-smokers, it has to be borne in mind that this figure does not include consumers of *snus* (smoke-free tobacco for oral use, snuff) which is about 20% in men and 4% in women.[137]

A ban on smoking in restaurants and bars has been debated by the public since the beginning of the 1990s. The formal proposal in autumn 2003 was followed by an expected majority vote. The ruling will be implemented from 1 June 2005.[417] Survey data suggest that seven out of ten in the population and three out of four restaurant owners are in favour of smoke-free restaurants.[137]

The most successful factors in Swedish tobacco control have been legislation and debate; the dynamic involvement of the civil society; a gender sensitive approach in smoking cessation; the focus of several campaigns on the tobacco industry instead of blaming victims, i.e. smokers;[d] and a sustained focus on passive smoking. The latter, in particular, demonstrates the importance of guidelines backed up by legislation. For example, a regulation including general guidelines for smoke-free public places and workplaces and issued in 1983, accompanied by an educational campaign, had a significant effect. Since then, many steps have been taken to combat passive smoking, resulting in strong public support for smoke-free environments.[137]

Other European countries

The important achievements of other countries should not be ignored. France, for example, is known for its early introduction of a total advertising ban (direct and indirect advertising, and sponsorship) in 1993[140] and a commitment to tobacco control by a series of health ministers since 1988 (starting with François Mitterand's administration but with the exception of Jacques Chirac), spearheaded by a strong media-based lobbying of a handful of committed medical practitioners.[141 142]

Austria's neighbour Italy, too, has had advertising bans since 1962, with provisions for fines since 1983 and the inclusion of indirect advertising and sponsorship since 1991.[140] In 2000, the Italian health minister and cancer specialist Umberto Veronesi, introduced a proposal to ban smoking in public and private indoor areas open to the public, including bars, restaurants, prisons, and police stations, and to enable law suits against tobacco producers. The government approved the smoking ban and it became law before the end of 2002, with one year for restaurants and bars to comply. People caught smoking in public places are fined €250, a sum that can be doubled if children or pregnant women are present. If restaurants and other public places wish to permit smoking they must set aside a smoking room and install a ventilation system – or risk a fine of €2,000 and temporary closure, a real revolution.[143-145] According to Veronesi, the proceeds from the fines should be used to fund anti-smoking campaigns.[145] Bar and restaurant owners are not obliged to provide designated smoking areas but if so, the whole premise has to be smoke-free. A second law which came into force on New Year's Day 2004 limits the availability of cigarettes in vending machines.[146] Since 1 March 2004, smoking has also been banned on Italy's Eurostar trains.[147]

Ireland has introduced a ban on smoking in all workplaces, including restaurants, pubs and bars in March 2004, thus being the first country within the European Union with a complete ban on smoking in the workplace. The ban also provides severe fines of around £2,000 (€3,000) for those caught smoking illegally.

In the United Kingdom, despite growing public support for a complete ban on smoking in public places, at present, there are no official restrictions for smoke-free environments in restaurants, pubs and bars; these are purely a matter of voluntary agreement. The government has, however, committed considerable resources to support smokers wishing to quit.

Poland, on the other hand, is outstanding within the eastern European countries. With the collapse of the communist system, Polish tobacco control advocates faced new challenges and

[d] Several campaigns have been addressing the strategies of the tobacco industry – e.g. the booklet "Smart Promotion" on tobacco advertising; the billboard poster campaign "Welcome to the Marlboro Country: Non-Smoking Generation" which received a powerful reaction in the media; and the "Swedish Match Alternative Report" which prompted two big insurance companies and part owners of Swedish Match to sell their shares because it was no longer ethically defensible.[137]

opportunities. Production and sale of tobacco products have been privatised (by the end of the 1990s, more than 90% were controlled by multinational corporations), a previous concession to the multinationals forced the government to keep tobacco taxes low for several years, and there was strong lobbying by the tobacco industry of the emerging class of politicians and a most effective marketing strategy. However, already in 1990, the first tobacco control activities started, leading to a draft tobacco control bill. Despite enormous pressure from the tobacco multinationals, the Polish government has enacted comprehensive tobacco control legislation first in 1995 (with support from an overwhelming majority of all parties), and amended by a law in 1999. The 1995 Law for the Protection of Public Health against the Effects of Tobacco Use was far ahead its time compared to most western European laws on tobacco control.

> "With the exception of two areas – lack of a total advertising ban and of a fund dedicated to improving smoker's health – the new law included all the actions outlined in the WHO's gold standard for tobacco control. The Polish legislation effectively provided for the protection of non-smokers and introduced the world's largest health warnings on cigarette packs. It also obligated the government to prepare annual action programs for controlling the health consequences of cigarette smoking. Implementation reports have been presented to Parliament every year since then".[148]

The 1999 law strengthened the provisions of the 1995 law, in particular introducing a comprehensive ban on advertising and sponsorship. As a result, smoking rates are now declining and health indicators improving.[148 149]

Reducing smoking: Evidence from international experience

Important steps toward successful tobacco control policies have been undertaken in many overseas countries, most notably in some states of North America, Canada, Australia, New Zealand, and Thailand.

This overview as to the effectiveness of interventions at state- and community level contains selected aspects of these programmes and is followed by two reviews of the effectiveness of state-level interventions in North America and the effectiveness of community-level tobacco control policies in North America and Canada.

North America

In North America, in particular two states are famous for their achievements in tobacco control. In California, the "largest and most innovative program in the world"[59] was initiated by activists from the environmental movement in 1988, viewing tobacco as a social and political problem and going after the tobacco industry directly and aggressively. This led to a $90 million per year tobacco control programme over an eight year period, operated by the State of California. One third of these generous funds went for school-based prevention and education activities, and two thirds supported a comprehensive anti-tobacco health education effort comprising local programmes, a state-wide media campaign, and surveillance and evaluation. The approach focused on a social norm change, aiming to influence indirectly current and potential future tobacco users "by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible".[409] The strategies of policy, media, and programme interventions were based on a comprehensive, multiple channel, multiple target approach, with a strong scientific basis. The direct and uncompromising efforts to expose the tobacco industry

as a very powerful, deceptive, and dangerous enemy of the public's health have cast smokers as the victims of the industry rather than villains and enabled new coalitions and partnerships. Following these initiatives, four broad priority areas were established: protecting people from exposure to second-hand tobacco smoke; revealing and countering tobacco industry influence; reducing youth access to tobacco products; and providing cessation services.[163 409]

During these eight years, per capita cigarette consumption in California has declined by over 40%. At the end of this period, virtually all indoor employment locations, including restaurants and bars, were smoke-free; 64% of all homes enforced a voluntary smoking ban; and 87% of all children and adolescents were protected from second-hand smoke in their homes. The illegal sale of tobacco products to minors declined from 52% in 1994 to 13% in 1998. But, as the Californian health department proudly adds:

> "Most reassuring of all, recently disclosed tobacco industry documents state that the 'environment for the sale and use of tobacco products in California continues to deteriorate', that California's anti-tobacco program 'enjoys a high rate of awareness and appears to be having the intended effect on smoking attitudes', that advertisements which portrayed the industry unfavourably were 'among favorite ads for most respondents' and were 'generally seen as believable, even among many smokers'"[409] (cited reference in quotation: Minnesota case document no. 2023012755).

Unfortunately, in 1992 the programme was cut back and the early successes in reduced smoking prevalence did not persist to the same extent.[161 418]

In Massachusetts, a clean indoor air act was passed in 1987 followed by other incisive interventions, such as the use of tobacco excise tax for the creation of the Health Protection Fund and the funding of the Massachusetts Tobacco Control Program; a $14 million media information campaign on the negative health effects of smoking, aiming to change public opinion, perception and attitudes toward smoking, coupled with a grass roots social movement that changed community norms around smoking and reached out to help smokers to quit; funding of community-based services throughout Massachusetts; and the provision of highly structured centre based nicotine addiction treatment services.[164]

Canada

Canada passed a Tobacco Restraint Act as early as 1908, although it took almost 60 years before tobacco regulation would again appear on the federal policy agenda, and another 20 years before the federal government would take legislative action against smoking and the tobacco industry. However, between 1986 and 1997, four important anti-tobacco acts were passed. Despite several political obstacles caused by both the tobacco industry and nine years of conservative political administration, by the end of 2000 Canada possessed a comprehensive, internationally recognised anti-tobacco strategy combining taxation, legislation and educational programmes. At present, there is extensive protection from second-hand smoke in workplaces, in public places, including restaurants and bars in some of the larger cities. In Canada, where the provinces have the ability to "ratchet up" the federal regulatory framework, by the turn of the 21st century, 40 municipalities banned smoking entirely in restaurants, and 25 banned smoking in bars. The cities Toronto and Victoria are known for their high level of smoke-free environments. In 1993, Toronto was the first to set aside 50% of seats for non-smokers in restaurants and bars; in early 2000, the British Columbia government instituted a province-wide ban on smoking in all restaurants and bars, despite the opposition of the hospitality industry and its unions that claimed to be reluctant to alienate smoking customers, especially tourists.[419]

By the mid 1970s, when most of Europe was shrouded in smoke and the idea of smoke-free places would have been unimaginable, community-based groups of activists started to push for smoke-free environments, starting at the municipal level with smoking bans in elevators, food stores, and other confined spaces, and then pushing for smoking bans in public places. Although the groups themselves were highly sceptical about the success of these efforts, several cities passed more limited laws which were increasingly accepted as the public grew used to them.[166] From 1986 these efforts moved to the national level. The Non-Smokers' Health Act gave all federally regulated workers the right to a smoke-free workplace. Flight attendants, passenger train workers, and intercity bus drivers fell under this law. Naturally, implementation was difficult at the beginning and companies feared a loss of business (particularly the airlines were very successful in retarding the implementation of the law). However, one strategy was particularly noteworthy. At a point when there was a risk that intercity buses would be exempted from the non-smoking law, instead of attacking the government, Canada's Non-Smokers' Rights Association and the Canadian Cancer Society approached the bus companies directly.

> "It was pointed out that other forms of transportation were going smoke-free and that the busses would suffer from a 'lower-class' image if they continued to allow smoking. This happened precisely when the industry was trying to move up-market. The result was that the bus companies demanded to be designated smoke-free, proving that allies can often be found when they are creatively sought".[166]

Canada has also become very well known for its portrayal of real life scenarios of people who suffered from smoking-related cancers in television advertisements, especially the famous case of the former waitress Heather Crown who developed lung cancer as a result of prolonged exposure to second hand smoke and who became a national heroine. Similarly, Canada was the first country to have blunt health warnings printed on each cigarette pack, combined with gruesome pictures of smoking-related disease covering half of the surface area of packets; these later inspired similar EU legislation. It also forced the disclosure of additives and many of the toxins in tobacco smoke. In summary, Canada's efforts to inform consumers about the risks of smoking have led to groundbreaking changes in labelling. In addition, Canada was the first country to end smoking on international commercial passenger flights, and Canadians played a key role in international efforts to remove second-hand smoke from air travel.[166]

Australia and New Zealand

Australia and New Zealand have also comprehensive tobacco control strategies. In it's Work Programme on Tobacco Control 2000/2001, the government of New Zealand has envisioned a set of policy and legislative developments, health promotion, law enforcement, and information, research and evaluation.[420] Its Tobacco Control Plan identifies the need to promote a social and physical environment that protects the public's health by reducing the harm from tobacco use and exposure to environmental tobacco smoke. Objectives include preventing the uptake of smoking; encouraging and facilitating quitting; preventing harm to the foetus, children and adult non-smokers; supporting monitoring, surveillance, and evaluation; and coordinating tobacco control activities. [420 421]

Already in 1990, New Zealand issued a Smoke-free Environments Act, part 1 of which was introduced to prevent the detrimental effects of smoking on the health of any non-smoker. In New Zealand, insurance excludes compensation for illness caused by passive smoking, thus raising the potential for litigation.[422]

Australia launched a National Tobacco Campaign in 1997, spearheaded by several anti-smoking measures at the regional or state level. This campaign continues, emphasising both cessation and use of the mass media, and addressing principally young adult smokers aged 18 to 40 years. The first campaign in 1997 was memorable and also distinctive in many ways. First of all, it took a new slant on anti-tobacco advertising by using challenging and memorable images of the harm done by smoking. This proved to be relevant and empowering for those smokers who intended to quit. The motto of this campaign was "Every cigarette is doing you damage", therewith marking a move away from focusing on disease risk to highlighting the immediate harmful consequences of health.[423] Other important features of this national campaign included strong links between anti-tobacco advertising and quit services, the latter being provided with substantial resources and funding for a range of supporting initiatives, particularly with regard to increased demand for cessation courses.[424]

An interesting finding of the Australian campaign might prove important in the argument against focusing on youth campaigns: Results indicate that adolescents are very aware of an adult focused anti-smoking campaign and think it relevant to them. In one study, 85% of adolescent smokers thought the campaign was relevant to them; 85% also thought it made smoking seem less cool and desirable.[375]

Another important finding is the relation between anti-tobacco advertising and quitting. The results of a survey on the immediate impact of the anti-tobacco advertising of the 2001 campaign on movement towards quitting show increased frequency of negative thoughts about smoking and an increase in quitting-related thoughts and actions. There was also evidence of a sustained increase in cessation activity for a month following the onset of the campaign.[425] Similarly, the number of phone calls to the national quitline increased after the onset of the 1997 campaign.[423]

Other experiences of this comprehensive campaign indicate the importance of alliances and a broad base for sustainability and the power of images.[423]

The present Australian national tobacco campaign *Quit Now* is a joint initiative by the Australian federal government and the Australian fashion industry. Among other activities it offers an extensive and informative website on smoking and passive smoking, provides information sheets to various smoking-related topics and a link to other anti-tobacco sites, and gives the telephone number of a help line.[426] Alongside the quitting programme, anti-smoking stamps were released in March 1990.[427]

As in Canada, the Australian anti-smoking group QUIT produced controversial television advertisements depicting patients going through various medical treatments for smoking-related cancers. The campaign sparked a huge response from the public, both supportive and critical. However, following complaints that it was too confrontational it had to withdraw them.[428]

Australia has also been introducing smoking bans in restaurants and public (not private) bars for some time. Since July 2003, new smoking laws for local pubs have been in force, requiring the removal of ashtrays from bars and prohibiting smokers from lighting up within 1.5 meters of the bar.

Brazil

Brazil is known for its National Day Against Tobacco[e], legislated for in 1986 and celebrated every year on 29 August. The week prior to it is reserved for national events and activities related to the issue. Most importantly, business was involved in tobacco control efforts from early on. For example, institutionalised honours certificates are awarded by the Ministries of Health and Labour to companies that attained certain standards such as workplace smoking bans, restricted smoking areas, and educational programmes. Companies' actions provided examples for others to follow; some big companies, such as *Banco do Brasil*, have even become a role model. After several years of slow development, the system has now become a success. Later, as a part of WHO's World No Tobacco Day, the honours certificate awards were extended to individuals who supported the government's campaign against tobacco. People in the media, writers, actors, lawyers, teachers, and athletes have received certificates. The awards have attracted considerable public attention and wide media coverage, and both the president and the health minister are increasingly seen at these celebrations.[429]

Thailand

Thailand, which in the words of Richard Peto is "really unique among developing countries", is not only another example of a country with a strong, comprehensive tobacco control policy but has also become a test case for the whole Asian region in the fight between national tobacco control policies and the tobacco industry, supported by the U.S. Trade Office that wanted to force Thailand to open its market to American companies. International support and the commitment of both Thailand's anti-tobacco groups and political decision makers have offered strong resistance. The dispute between the Thai government and the U.S. Trade Office was referred to a General Agreement on Tariffs and Trade (GATT) panel, with the WHO supporting Thailand and the European Union supporting the United States.[430] Finally, the GATT ruled that Thailand's import ban was contrary to trade provisions – a fact that recalls the situation in EU legislation where the dominance of economics over public health issues is also very clear.

Singapore

The National Smoking Control Programme (NSCP) aims to reduce smoking prevalence in Singapore by preventing the initiation of smoking among young people, educating, motivating and assisting smokers to give up smoking and promoting a climate conducive for non-smokers to remain free from the harmful effects of environmental tobacco smoke and establish non-smoking as a social norm.[431]

Although efforts to promote a smoke-free lifestyle started in the 1970s and a comprehensive, long-term national tobacco control plan was launched in 1986[431], Singapore's tobacco control policies can be described as a swift action with no compromises, rapid passage of legislation instead of noncommittal guidelines, exclusion of tobacco companies from anti-tobacco activities, and an exclusive role for government.[432]

[e] Literally translated: National Day of the Fight Against Tobacco.

Effectiveness of state-level tobacco control interventions in North America: a review

This section summarises a recent review of the effectiveness of state-wide tobacco control programmes in five states in North America (California, Massachusetts, Arizona, Oregon and Florida) by Michael Siegel. In summary, state-wide tobacco control programmes are found to be a very effective public health intervention, able to produce dramatic declines in per capita cigarette consumption and in smoking prevalence among both adults and young people. Within a short time, these declines can lead to a demonstrable reduction in mortality from heart disease. The magnitude of this reduction in morbidity and mortality can be substantial. Concerning the California programme, there is "probably no other public health prevention that comes close to this degree of effect on the public's health".[366] In developed countries, tobacco use has been identified as the chief preventable cause of death. Therefore, "comprehensive state-wide tobacco control programs should now be seen as the most critical public health intervention available".[366]

The two most successful tools have been found to be an aggressive anti-smoking media campaign and interventions on the local level. Specifically a televised media campaign is the most critical component within a tobacco control programme in the U.S. It has been shown that this leads to a lower smoking prevalence and to a reduction in youth smoking. The media campaign may serve as a core around which other essential elements of tobacco control activities can be arranged. It can also help to facilitate and support the second important tool, namely community-level initiatives. According to the findings of Siegel, these interventions at the local level are essential (for example, they can proliferate local clean indoor air ordinances) and should therefore form a specific focus of every programme. However, a review on studies on the effectiveness of community interventions on smoking cessation, described in the following subchapter, reached less optimistic conclusions.

Siegel concludes his review with the finding that the effectiveness of programmes depends on their intensity and the aggressiveness of the programme implementation. Of particular importance is continuity of funding, if possible over decades. The results of the various studies suggest that tobacco control programmes are powerful tools to reduce not only smoking prevalence but also morbidity and mortality and should therefore be made a permanent part of the public health infrastructure.[366]

Effectiveness of community interventions on smoking cessation in North America and Canada (review)

A systematic search on eight studies carried out in North America and Canada[f] showed no, or only moderate positive results that would indicate a significant influence of community interventions on reducing or stopping smoking among adults. Comparison between the various studies proved to be rather difficult, as they vary considerably in design, sample size, methods, data analysis, intervention period and types of intervention, definition of outcome measures and characteristics of participants. Definitive conclusions about the overall effectiveness of community-wide efforts and their possible generalisation are difficult. Community intervention trials are targeting all members of the community, not only the motivated participants of the study, and the observed effects may therefore be smaller than in more selective, individual studies. Nevertheless, it is a disappointing fact that the reviewed studies showed only little evidence of community interventions influencing the smoking behaviour of adults. Changes in smoking prevalence and quit rates due to intervention activities are very small or negligible, and the results do not seem to be very convincing (e.g. often no biochemical test was used to confirm the self-reported quit rates). The most influential factors affecting changes of smoking behaviour were education (& income) and age. These findings are consistent with the results found by analysing the data for Vienna.

Nevertheless, these and other trials have demonstrated the feasibility of activating entire communities in pursuit of health. They have also shown that the health care sector need not take sole responsibility for community health; the mass media, business, education, and other sectors can also adopt health as a priority. Through these trials, the wide range of resources and skills needed to achieve individual and organisational change becomes more visible.[442]

Recommendations that can be drawn from the analysis of these community intervention studies concern primarily the feasibility of activating communities and the potential role of local policy makers. However, there is still not much known about factors influencing health behaviour, and more research is needed, in particular targeting multiple levels of influence and with randomised controlled trials supplemented by other research methods. The lessons learned from the Stanford Five-City Project offer support for community-wide health promotion[438] and results from several community-based studies suggest that policy interventions can be very efficient in promoting health behaviour change.[442]

[f] The following studies on community interventions to reduce smoking in adults were investigated: COMMIT (Community Intervention Trial) Research Group 1995[433 434]; Royce et al. 1997[435]; Secker-Walker et al. 2000[436]; Lando et al. 1995[437]; Fortmann et al. 1995[438]; Fisher et al. 1998[439]; Voorhees 1996[440]; Schorling 1997[441]. Used databases: Medline, Health Star, BIDS (Embase), Web of Science, Cochrane, PubMed and Popline. Limitations to studies carried out in North America and Canada (including studies on minorities), and peer-reviewed articles published in reputable journals from 1990 to 2000. Selection criteria: randomised and non-randomised trials that assessed the effectiveness of community interventions in influencing smoking behaviour among adults. Reported outcomes had to include prevalence, quit-rate and/or change of stages in the process of quitting.

Lessons learned

The following two boxes summarise the experiences of various countries, showing which measures proved effective and which are in the interest of the tobacco industry.

What works?

Box G-1 Lessons learned: What works? Experiences of various countries[g]

Insights and overall lessons

- The results of various studies suggest that tobacco control programmes are powerful tools to reduce not only smoking prevalence but also smoking-related morbidity and mortality dramatically and should therefore be made a permanent part of the public health infrastructure (U.S., Finland; all).
- To change a pattern of individual behaviour that is notoriously resistant to change, a comprehensive strategy of regulation, taxation and prevention programmes is necessary (Canada; all).
- This strategy requires internal und external pressure on governments (Canada; all).
- Time and again, a key role was played by NGOs and by individuals – often very charismatic people – who showed extraordinary commitment and dedication. Through their knowledge and perseverance, they became credible spokespersons for their cause and won the ear of policymakers. Thus, a small group of dedicated and committed individuals can change the world (all).
- Effective advocacy has to be learned. Tobacco control advocates found that change is a slow, evolutionary process; they learned to expect setbacks and make use of them to turn defeats into victories; to take advantage of favourable opportunities as they arose, developing rapid-response, short-term strategies as well as long-term goals; and to be creative in seeking allies. Not least, they learned about the need for optimism and for a continuous, sustained effort (all).
- Strong political support and political champions are absolutely crucial to success (all). Public opinion polls have been influential in some countries, demonstrating to politicians clear popular support for strong policies to protect children and adults from the harm caused by tobacco use.
- Strong public support contributes fundamentally to the success of all tobacco control measures (all).
- Importance of alliances (all).
- Not all policymakers were won over by data on tobacco-related morbidity and mortality.
- The effectiveness of tobacco control programmes depends on their intensity and the aggressiveness of the programme implementation (U.S.).
- Close relation between anti-tobacco advertising and phone calls to quitlines (Australia).
- Amazing transformations in social norms can occur, spurred by changes in legislation, shifts in the socioeconomic context, and better public information. The media can have a

[g] Some of the countries who reported this experience are added in brackets. However, these examples are by no means exhaustive and in most cases there may be other countries who had the same experience.

powerful effect in influencing popular opinion and paving the way for legislation. Legislation both reflects and reinforces – or institutionalises – changing social norms (all).

- An understanding of the political framework and the legislative timetable of the country contributes to effective advocacy (knowing when to intervene, whom to target, cultivating favourable legislators, recognising when the right time has come, responding swiftly) (all).
- A successful approach to reduce smoking rates, increase cessation rates and prevent non-smokers from taking up smoking has to be comprehensive, at least comprising legislation, taxation, information and education, and support for cessation, and should address different audiences. The implementation of this comprehensive programme should ideally be a swift and concerted action, decisive and forceful.
- A comprehensive approach designed to change social norms is more effective in reducing tobacco use than focusing on individuals who smoke (all).
- It is difficult but not impossible to succeed against a force as rich and powerful as the tobacco industry (California, Canada, Finland, Sweden, Norway, Thailand).
- In each case, legislative successes were won in the face of vigorous opposition from a tobacco industry striving to defend its profits and market. Sometimes the legislation was weakened or delayed, or its implementation was inhibited. Compromises had to be made, but these sometimes paved the way for stronger follow-up laws a few years later (all).
- Victory is not assured even after many years of successful tobacco control policies, and the war against misinformation, ignorance, addiction, preventable disease, and premature death is a long and hard battle, but worth it in many aspects. In other words: The fight will be hard and the battle will never end (all).
- Persistence is essential. Never give up.

What works? What are the crucial elements?

Comprehensiveness & sustainability

- Tobacco control policies and strategies must be comprehensive. Single initiatives are not enough; real impact comes from a combination of education and information, legislation, taxation, media campaigns, community action, professional involvement, prevention and cessation programmes in various settings, prohibitions on smoking in public places, and complete bans on advertising and promotion of tobacco and tobacco brands (all).
- Long-term, comprehensive policy elements which reinforce each other are crucial and more effective in reducing smoking than campaigns or any other single measure (all).
- Sustained funding over a long period is important and necessary, at least continuity over a couple of years and if possible over decades (all).
- Sustainability due to a broad base, e.g. drawing together federal and state governments, NGOs and service providers (quitlines) (Australia).

Pillar 1: Legislation

- Comprehensive legislation is absolutely crucial in tobacco control. Legislative measures are far more effective than voluntary agreements, especially in reducing ETS (all).
- Legislation must be coupled with strong attention to implementation and enforcement (all).
- Adequate penalties for violations of the law (U.S.). Sanctions have proved supportive in the implementation of programmes (Canada).

Pillar 2: Taxation

- Tax increases and price rises are very effective in controlling tobacco consumption (all).
- Strong, effective tobacco control policy that includes tax increases and complementary health promotion efforts brings two different interest groups together, including ministry of health and ministry of finance (all).

Pillar 3: Advertising, promotion and sponsorship

- Advertising and promotion of tobacco products have an enormous impact on demand and social associations with smoking. Therefore, a total advertising ban should be part of every comprehensive tobacco control programme.

Pillar 4: Information and education, media campaign

- Information and education, targeted at different audiences, are another essential element of a comprehensive tobacco control programme. In particular, broad, sustained, and aggressive media campaigns are very successful transmitters of educational contents.
- Varying, impressive and highly visible health warnings on cigarette packs make smokers feel that message is relevant to them (all countries that display this kind of warning).
- Power of images at both warning labels and media campaigns (Canada, Australia).
- Portrayal of real life scenarios of people going through treatment for smoking-related diseases evoke strong emotional reactions (pro and contra) and have proven to be memorable and powerful tools (Canada, Australia).

Pillar 5: Smoking bans

- Prohibition of smoking in workplaces and all public places, including public transport, restaurants and bars, reduce tobacco consumption, prevent socially cued smoking, support smoking cessation, and prevent up-taking of smoking by non-smokers, both adults and youths (all).

Pillar 5: Cessation

- Demand for and usage of quitlines and cessation programmes will increase after onset of anti-smoking campaign.

Allies and coalitions

- Alliances are most important, both for effectiveness, credibility and cost-sharing (all).
- Collaboration between government and health authorities, non-governmental organisations, civil society groups, and committed individuals is essential (all).
- Coalitions of individuals and organisations may bring new skills and perspectives to bear on the issue. Broad-based groups such as consumers' rights groups, development agencies, activists from the environmental movement, women's rights activists, lawyers, and religious organisations made important contributions in the various countries.
- While much can be done with little money if funds are used wisely, lack of an organisational home and a minimal level of financial resources can make it hard to operate effectively. Working collaboratively with national and international agencies can help provide access to sustained, if limited, resources (Bangladesh, Brazil, Canada, Poland, South Africa, and Thailand).

Strategy for anti-smoking groups

- Prepare the ground: (1) Educate the public (advertising campaigns, well-briefed media, public opinion polls). (2) Build your allies (strong support from NGOs and political champions). (3) Neutralise your opponents (frame message to your advantage) *(Heather Selin from the Pan American Health Organization).*[134]
- Coordination of media activity and links with cessation services (Australia; all).
- Media advertisements should be targeted at different audiences. Exposure of the tobacco industry allows smokers to feel they are victims rather than villains (California, northern Europe).
- The central focus of a successful campaign should be to change social norms towards smoking (social environment), so that tobacco use is viewed negatively by everyone in a community. Change in social norms and the social environment of local communities must come from the grass-roots level up, not mandated from the top (California; and others).
- Sound research and evidence are extremely important as a basis for good policy decisions. Building, publishing, and widely publicising of a solid information base proved enormously useful to policymakers and advocates and helped promote changes in public attitudes and awareness that gradually led to change in social norms (nearly all).
- Use and create political opportunity and follow precedents set elsewhere (U.S.).

High level support

- Although support at community level is important, national anti-smoking campaigns are much more effective than purely community-based activities (U.S.).
- Moral and financial support from government and strong commitment of decision makers are essential (all).

Activities on the local and regional level

- Direct approach to companies or establishments by civil society groups or NGOs or committed individuals to persuade them to introduce smoking bans pointing to the "lower class" image, the up-coming competition with establishments/companies who provide smoke-free environments, and the likelihood of subsequent loss of business if not doing so (Canada).

Youth oriented measures

- Youth oriented measures, if not part of a comprehensive tobacco control programme, are very limited in their success, or even lead to adverse results.
- Confining tobacco control activities to children and adolescents is not the answer to the alarmingly high and still increasing smoking prevalence among children and teenagers. Youth smoking will decline when more adults stop smoking, and when adults take action to de-glamorise tobacco use (California, Australia, northern Europe).
- Results indicate that adolescents are very aware of an adult focused anti-smoking campaign and think it relevant to themselves (Australia).
- Age limits for the purchase of tobacco products are more or less useless. For minors, cigarettes are accessible anytime and anywhere, particularly when vending machines are available.

Recommended procedure

- Look for allies in the government and beyond, cooperate with the media and service providers (quitlines, cessation programmes, etc.), and take advantage of opportunities as they arise. Use research to obtain information and to provide it to decision makers and the public. Be creative (California, Canada, France, Australia, ... - all).
- Address youth within a multi-targeted campaign. Establish well-funded, comprehensive tobacco control programmes that de-normalise tobacco use; increase tobacco taxes; bar the tobacco industry from spending billions of dollars a year trying to addict anyone, regardless of age; strictly regulate tobacco production, manufacturing, marketing, and sales (California, Australia, northern Europe).

Lessons about what NOT to do

The Californian experience has revealed how some tobacco control programmes are actually in the interests of – and therefore often supported by – the tobacco industry.[409] Although not all of them are fully applicable to the situation in Austria, many of them, and related measures can be found in Austria; they are therefore listed in the following box.

Box G-2 What does not work? Tobacco control programmes that meet the interests of the tobacco industry

Industry-friendly, ineffective measures and programmes

- Funds to be diverted into medical services rather than going into anti-smoking campaigns *[fully applicable to Austria]*.
- Delay of legislation, draft of weak and insufficient legislation, no law enforcement, conferment to voluntary agreements *[fully applicable to Austria]*.
- Support for federal and state laws that pre-empt regulations on tobacco (to block community action and accompanying shifts in social norms) *[Austria: no real position on it, but the basic opinion is that it should be based on voluntary agreement]*.
- Support for laws that penalise children for possession of tobacco products (to increase the "forbidden fruit" appeal of tobacco and to divert attention away from the responsibility of the merchants and the industry for the tobacco addiction of young people) *[not applicable to Austria]*.
- Support for programmes that focus exclusively on children and teenagers *[fully applicable to Austria]*.
- Support for efforts to eliminate youth access to tobacco and to criminalise possession of tobacco products by minors *[Austria: no discussion on this issue; only setting of age limits for purchase of tobacco products, no sanctions]*.
- Support for narrowly focused efforts to reduce adult smoking through a clinical cessation approach that would target only smokers (rather than targeting entire communities and emphasising the dangers of exposure to second-hand smoke in an effort to achieve social norm changes regarding tobacco use) *[fully applicable to Austria]*.

APPENDIX H

Effective interventions, actions and programmes by the WHO and the EU

The World Health Organisation has taken important initiatives towards a tobacco free Europe: the Tobacco Free Initiative (TFI) with its Framework Convention on Tobacco Control (FCTC) (run from Geneva) and the European Strategy on Tobacco Control (ESTC) within the programme Tobacco Free Europe (TFE) (run from Copenhagen). Together with the directives of the European Union, which can be enforced in the European Union member states, these measures are presently the cornerstones of European tobacco policy.

Apart from legislation, which forms the central component in the European Union's role in tobacco control, the Union is also funding tobacco control and tobacco control research initiatives. On behalf of its member states the EU has been playing a key role in negotiating the WHO's Framework Convention on Tobacco Control, an international treaty on global tobacco control. In addition, special programmes aiming to reduce smoking are the EC Public Health Action Programme, where preventive measures are promoted, and activities within the framework of "Europe Against Cancer". The following section examines some of the programmes developed by the EU or the WHO.

WHO: Tobacco Free Initiative (TFI) and Framework Convention on Tobacco Control (FCTC)

The Framework Convention on Tobacco Control is targeted at the massive public health impact of tobacco, which is seen as a silent, worldwide epidemic.[443] This convention arose from the preliminary work of the Tobacco Free Initiative. On 24 May 1999, the World Health Assembly (WHA), the governing body of the World Health Organization, paved the way for multilateral negotiations to develop a set of rules and regulations that will govern the global spread of tobacco and tobacco products in the 21st century. The then 191-members of the WHA unanimously backed a resolution calling for work to begin on the Convention – a new legal instrument that could address issues as diverse as tobacco advertising and promotion, agricultural diversification, smuggling, taxes and subsidies.[398] A record 50 nations (not including Austria) took the floor to pledge financial and political support for the Convention.[20]

Adopted on 21 May 2003 by the now 192 member states of the 56th World Health Assembly, the Framework Convention on Tobacco Control represents the first global health strategy aiming to curb tobacco use worldwide by providing the basic tools for countries to enact comprehensive tobacco control legislation.[21] Key obligations in the treaty encourage countries to:

- enact comprehensive bans on tobacco advertising, promotion, and sponsorship,
- obligate the placement of rotating health warnings on tobacco packaging that cover at least 30% (but ideally 50% or more) of the principal display areas and conclude pictures or pictograms,
- ban the use of misleading and deceptive terms such as "light" and "mild",
- protect citizens for exposure to tobacco smoke in workplaces, public transport, and indoor public places,

- combat smuggling, including the placing of final destination markings on packets,
- increase tobacco taxes.

However, as the term "encourage" already suggests, only a few of these measures, which form a minimum standard that countries can exceed, were made obligatory, "a direct result of intense pressure from a handful of countries, particularly the USA, Japan, and Germany".[181]

WHO Europe: Tobacco Free Europe (TFE) and European Strategy for Tobacco Control (ESTC)

This program's main goal is to focus international attention, resources and action on the tobacco epidemic and efforts to control it in Europe. It works to ensure that governments, international agencies and other partners are well equipped to implement national and transnational approaches to tobacco control. This programme works closely with the World Health Organization's Tobacco Free Initiative. It also sponsors World No Tobacco Day.

In February 2002, the European Ministerial Conference for a Tobacco-free Europe in Warsaw declared the tobacco epidemic as one of the greatest public health challenges facing Europe.[177] Member States committed themselves to support strongly the preparation of a comprehensive FCTC and to work towards a set of integrated and comprehensive tobacco control measures, the most important being: high taxes, bans on tobacco advertising, sponsorship and promotion, protection against involuntary exposure to environmental tobacco smoke in public places and workplaces, access to cessation measures, and strict controls on smuggling.[132 177] Austria voted for this declaration, which is, however, meant to be purely programmatic and does not lead to any binding legislation.

EU: "Europe Against Cancer" program (EACP)

The Community action plan against cancer was adopted for the period of 1 January 1996 to 31 December 2000. The plan contains 22 measures, covering data collection, public information, education, training on cancer for health-care workers, early detection and systematic screening, studies and measures relating to the quality of care and research.[444]

Since 1986, the Europe Against Cancer Programme has supported projects that inform the public about the dangers of smoking. In particular, it supports the International Network of Women Against Tobacco in Europe (INWAT)[106] and the European Network on Young People and Tobacco (ENYPAT)[62].

EU: Feel Free to Say No

This is a European Commission information campaign that primarily targets young people between ages 12 and 18, an age range during which more than 80 percent of smokers take up the habit. Austria joined this 3-year national campaign, starting on the World No Tobacco Day in May 2002.[445] However, there have been major concerns about this campaign that many tobacco control activists believe mimics the tobacco industry's so-called "youth smoking prevention" campaigns. It is generally seen as a waste of money, and it demonstrates the difficulties of developing a campaign that will work across the whole of the EU.

EU: European Network for Smoking Prevention (ENSP)

Funded by the European Commission, the European Network on Smoking Prevention (ENSP) is the main coordinating body for smoking prevention. It is governed by a general assembly consisting of two representatives from each of the national coalitions against tobacco from the 15 member states of the European Union and of one representative from each of the specialized European tobacco control networks (INWAT Europe, ENYPAT, European Network of Smoke-Free Hospitals).[18]

WHO: World No Tobacco Day

World No Tobacco Day, based on the WHO Resolutions WHA40.38 of 1987 and WHA42.19 Tobacco or Health of 1989, is celebrated around the world every year on May 31. The Member States of the World Health Organization created World No Tobacco Day in 1987 to draw global attention to the tobacco epidemic and the preventable death and disease it causes. This yearly celebration informs the public on the dangers of using tobacco, the business practices of tobacco companies, what WHO is doing to fight the tobacco epidemic, and what people around the world can do to claim their right to health and healthy living and to protect future generations. Every year a different theme is chosen, recent ones addressing the topics "Second hand smoke kills (2001), "Tobacco free sports" (2002), and "Tobacco free fashion, tobacco free sports" (2003).[446]

APPENDIX I

EU legislation and non-binding provisions

Table I-1 Major EU tobacco control regulations (including recommendations) 1989 – 2003

Regulation	Directive No. (Active directives in bold)	Provisions
Labelling and tobacco products (1989, 1990, 1992, 2001)		
Labelling Directives (& smokeless tobacco), 1989, 1992	89/622/EEC	Tar and nicotine yield to be printed on the side and health warnings on the front of each of pack. Each warning to cover 4% of the appropriate surface, 6% for countries with two official languages & 8% for countries with three official languages.
	92/41/EEC	Amended Directive 89/662 by introducing warnings for packaging of tobacco products other than cigarettes and banning the marketing of certain tobacco products for oral use.
Tar yield Directive, 1990	90/239/EEC	Sets a maximum tar yield of 15mg per cigarette by 31st December 1992 and 12mg per cigarette from 31st December 1997.
Tobacco Products Directive, 2001 (replaces directives 89/662/EEC, 92/41/EEC & 90/239/EEC)	**2001/37/EC**	Specifies a reduction in tar yield from 12 to 10mg, nicotine and carbon monoxide limits, health warnings to cover 30% of the pack front, additive and ingredient disclosure, a ban on misleading product descriptors such as 'light' and 'mild'. Passed on 18 July after being challenged in the European Court of Justice.
Advertising and sponsorship (1989, 1998, 2003)		
"Television without frontiers", or Television Broadcasting Directive, or Television Advertising Directive, 1989 (Minor amendments made by Directive 97/36/EC)	89/552/EEC	Bans all forms of television advertising for tobacco products.
Tobacco Advertising and Sponsorship Directive, 1998 (annulled October 2000)	98/43/EC	A comprehensive ban on tobacco advertising and sponsorship.
Advertising and Sponsorship Directive	**2003/33/EC**	Bans advertising of tobacco products in printed media, on the internet and radio, and cross border sponsorship of radio programmes and events by tobacco companies.
Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control (in addition to Advertising and Sponsorship Directive)	**2003/54/EC**	Recommendations as to reduction of availability and supply of tobacco products to children and adolescents, ban on advertising not included in Advertising and Sponsorship Directive, and improvement of protection against passive smoking.

Taxation (1992, 1995, 1999, 2002)		
Tax Directives, 1992, 1995, 1999 & 2002 (1999 & 2002 Directives amend earlier Directives)	92/78/EEC 92/79/EEC 92/80/EEC 95/59/EEC	Set minimum levels of duty on cigarettes and tobacco.
	99/81/EC	Requires an overall excise duty (specific and *ad valorem* combined) of at least 57% of the final retail selling price of the price category most in demand, plus a VAT rate of 13.04%.
	2002/10/EC	Introduces a fixed minimum amount of taxation expressed in Euros by requiring that the minimum excise rates outlined above shall be at least €60 per 1000 cigarettes for the price category most in demand.
Smoking in the Workplace (1989, 1992)		
	89/654/EEC	Council Directive of 30 November 1989 concerning the minimum safety and health requirements for the workplace (first individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC.
	92/85/EEC	Council Directive of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding (tenth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC).

Source: *GILMORE & ZATONSKI (2002)* [149] *and GILMORE et al. (in print)*[185]

The three latest directives and recommendations of the European Commission are presented in the following table.

Table I-2: Legislative situation in 2003 as to most important regulations

Directive No. (Date of issue)	**Contents**
2001/37/EC (18 July 2001)	**Directive of the European Parliament and of the Council on manufacture, presentation and sale of tobacco products (Tobacco Products Directive).**[188] • Sets limits for tar, nicotine and carbon monoxide yields • Introduces larger health warnings and yield indications, and the faculty for Member States to introduce graphical/pictorial warnings • Promotes the development of measurement methods for yields of substances other than tar, nicotine and CO • Obliged Member States to disseminate information on ingredients.
2003/33/EC (26 May 2003)	**Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products (Advertising and Sponsorship Directive).**[189] • Prohibition of advertising of tobacco products in printed media and the internet • Prohibition of radio advertising of tobacco products and of sponsorship of radio programs by tobacco companies • Prohibition of sponsorship of cross-border events and of any promotional-free distribution of tobacco products in this context • Member States must ensure that persons or organisations with a legitimate interest may take legal action against advertising or sponsorship banned by the Directive • Enters into force as from July 2005.
2003/54/EC (25 January 2003)	**Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control.**[190] Member States are recommended: • to reduce the availability and supply of tobacco products to children and adolescents • to ban certain types of advertising (those not included in the Advertising Directive) • to monitor the promotional activities of the tobacco industry • to improve protection against passive smoking and set tobacco prices at high level to discourage consumption.

Source: European Union, poster at 12th World Conference on Tobacco or Health, Helsinki 2003.

The following sections deal in more detail with regulations on advertising and sponsorship, labelling and cigarette composition, and smoking in public places and workplaces. A more comprehensive description of these issues and the history of the various directives can be found elsewhere.[27 175 176]

Restrictions on tobacco advertising and sponsorship

Beginning in 1985, the European Community began to develop legislation to fight tobacco use in Europe under the Europe against Cancer Programme. A crucial element of this programme was a directive, initially proposed in 1989, ending tobacco advertising and sponsorship in Europe by 2006. The tobacco industry mounted a major and sustained lobbying campaign against the directive via a number of interested organisations, including governments (the United Kingdom, Germany, and The Netherlands – to a lesser extent also Greece and Denmark), that appears to have contributed to the delay of its adoption for nearly a decade, until 1998. A comprehensive EU ban on direct and indirect tobacco advertising and sponsorship was then passed, but as noted above was annulled in the European Court of Justice on 5 October 2000.[27 176]

This ruling led the Commission to draft a much weakened directive which only bans cross-border promotions, namely advertising in print media, radio and the internet, and sponsorship. However, it does not restrict or ban indirect advertising and advertising on billboards. This new directive was proposed by the European Commission on 30 May 2001 and passed on 26 May 2003. After being adopted at a first reading by the Council, the German and United Kingdom delegations voted against it.

The challenge and subsequent annulment of the comprehensive advertising directive of 1998 (Directive 98/43/EC) demonstrated the power of this highly organised lobbying, starting from the tobacco industry which lobbied at the level of EU member state governments as well as on a pan-European level, and which effectively swamped EU officials. As Neumann and colleagues surmise, "the industry sought to prevent passage of the directive within the EC legislature, to substitute industry-authored proposals in place of the original directive, and if necessary to use litigation to prevent implementation of the directive after its passage. The tobacco industry sought to delay, and eventually defeat, the EC directive on tobacco advertising and sponsorship by seeking to enlist the aid of figures at the highest levels of European politics[a] while at times attempting to conceal the industry's role".[176]

Germany and the United Kingdom were consistent allies of the tobacco industry. However, while the election of a new government in 1997 changed the position of the United Kingdom, "Germany remained resolutely opposed, exerting strong pressure on other countries to support its position".[27] There is also suspicion that other states have been happy to hide behind the German obstruction.[175] In particular, the 1998 EU Directive was challenged by the German Government and four British tobacco companies.[27 142] It should be noted that, like Germany, Austria voted against the 1998 directive (Denmark and Spain abstained). Since October 2000, Austria has changed its position towards a less antagonistic role, whereas Germany is again challenging the new directive which was passed in 2003 *(see below and Chapter 9)*.

According to Neumann and colleagues, the tobacco industry's strategies and tactics for opposing controls on advertising in Europe were similar to those it used to oppose tobacco control efforts elsewhere – as, for instance, in the USA, in Switzerland, at the WHO, and at the International Agency for Research on Cancer (IARC).[27 176 447 448]

On 26 May 2003, the Advertisement and Sponsorship Directive 2003/33/EC became effective and replaced the annulled Directive 98/43/EC. It should enter into effect on 31 July 2005 but

[a] These figures included the former German Chancellor Helmut Kohl, former British Prime Minister Margaret Thatcher, British Secretary of State Kenneth Clarke, and European Commissioner Martin Bangemann.[176]

Germany challenged it at the end of July 2003. Although much weaker and more restricted than its predecessor, this new directive is very important for the initiation and the progress of tobacco control measures in the European member states and the acceding countries. Although a minimal standard, the new directive in particular aims to harmonise national regulations on tobacco advertising in printed media, radio broadcasting and information society services, as well as sponsorship of events with cross-border effects with the aim of promoting tobacco products. Moreover, it seeks to ban, with a few limited exceptions, advertising and sponsorship of tobacco products in the situations mentioned above. So, in essence, it aims at an advertising ban in the media, printed material directed at the public, and the internet. However, as presently worded, it does not represent a total advertising ban, as, for example, advertisement on billboards is still allowed, as well as indirect advertising. Excluded is also tobacco advertising in cinemas, bill boards, etc. as these do not cross borders. The directive does, however, include a ban on sponsorship of sporting events in member states by tobacco producers and radio advertising with a trans-boundary impact and sponsoring of radio programmes by tobacco producers. This directive should guarantee the equal treatment of the various media. A former EC-directive (the so-called "Television without frontiers" Directive 97/36/EC) already forbids TV advertising of tobacco and sponsorship of programmes by tobacco producers.

The member states are obliged to ensure the implementation of the directive by imposing proportional, effective and deterrent sanctions where an offence takes place.[284] The only sanction the Austrian tobacco law provides is a symbolic fine of about €7,000 in case of violating the advertising restrictions (the sum may be doubled in case of a repeated violation) which seems to be not even enforced *(Chapter 8)*.

According to the European Commission, all member states have already placed some degree of restriction on tobacco advertising and sponsorship. However, the scope of this national legislation ranges widely, from total bans on tobacco advertising as in France, Italy, Portugal, Finland, and Belgium, to systems based largely on industry self-regulation, as in the Netherlands.[176] With its partial advertising ban, Austria is situated somewhere on the less active part of this spectrum.

Labelling & cigarette composition

In the late 1980s and early 1990s, the European Union issued a series of directives on labelling and tar yield. The labelling directives required all cigarette packs to display tar and nicotine yields on the side of cigarette packets covering 4% of the surface; in addition, a clearly visible health warning had to cover at least 4% of the front side of each pack. The 1990 Tar Yield Directive 90/239/EEC set a maximum tar yield of 15mg per cigarette by 31 December 1992, reduced to a maximum tar yield of 12mg by 31 December 1997.

Important as these directives were, the tobacco industry found loopholes, which led to moves to strengthen the directive. For example, most cigarette packs used an elegant gold or silver lettering for the health warnings offering only minimal contrast.[27]

On 7 January 2000, following recommendations of the High Level Cancer Experts Committee, the Commission suggested revising the three existing directives on the amount of tar in cigarettes and the labelling of tobacco products in the context of the general move to European integration. On 15 May 2001, after considerable resistance in the Council of Ministers, particularly from Germany and Luxembourg, the new Tobacco Products Directive was accepted by the European Council and Parliament and passed on 5 June 2001.[27] [284] The directive specified a further reduction of maximum tar yields and for the first time regulations on maximum limits

on nicotine and carbon monoxide yields. It also included the demand for greatly enlarged and more explicit health warnings covering 30% of the front surface and 40% of the back surface of each cigarette pack, the disclosure of ingredients and additives, and a ban on misleading product descriptions such as "light" or "mild". It should eliminate (or at least approximate) continuing substantial differences between EU member states and improve the functioning and "smooth operation" of the internal market.[27] [b]

In particular, this binding directive specifies that from 1 January 2004 onwards, cigarettes that are marketed or produced in the European Union, may not exceed the following values: 10mg tar per cigarette, 1.0mg nicotine per cigarette and 10mg carbon monoxide per cigarette.[c] The contents of tar, nicotine and carbon monoxide are to be printed on the small side of each cigarette package, taking up at least 10% of the surface.

On one of the broad sides of the package a warning notice should be placed, taking up at least 30 percent of the surface. On the opposite side a complementing warning notice has to be printed, taking up at least 40% of the surface. Fourteen possible wordings were agreed.

1. *Smokers die younger.*
2. *Smoking clogs the arteries and causes heart attacks and strokes.*
3. *Smoking causes fatal lung cancer.*
4. *Smoking when pregnant harms your baby.*
5. *Protect children: don't make them breathe your smoke.*
6. *Your doctor or your pharmacist can help you stop smoking.*
7. *Smoking is highly addictive, don't start.*
8. *Stopping smoking reduces the risk of fatal heart and lung diseases.*
9. *Smoking can cause a slow and painful death.*
10. *Get help to stop smoking: (telephone/postal address/internet address/consult your doctor/pharmacist)*
11. *Smoking may reduce the blood flow and causes impotence.*
12. *Smoking causes ageing of the skin.*
13. *Smoking can damage the sperm and decreases fertility.*
14. *Smoke contains benzene, nitrosamines, formaldehyde and hydrogen cyanide.*

Furthermore, from 31 December 2002 onwards, member states have the option of putting coloured photographs or other kind of illustrations on cigarette packages to demonstrate the impact of smoking to health.

Deceptive terms such as "light", "ultra-light", "low tar", or "mild" are prohibited as these do not necessarily correspond to lower tar exposure.[27]

The new directive also requires that all additives in tobacco products must be analysed and declared. By 2004, a list of permitted ingredients for tobacco products will be developed by the European Commission. Particular consideration will be given to the potential for addiction of these ingredients. These measures, particularly the health warnings and ban on misleading descriptors, should form the basis for a high level of health protection.

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[b] Although the so-called "experts" committee recommended reduction in tar and nicotine levels, by this stage the tobacco control community had realised that such levels are rather meaningless.

[c] As an exception, the tar content for Greece is only effective as per 1 January 2007 (due to its difficult socio-economic situation).

Not surprising, the British Tobacco Manufacturers Association and the German Government have challenged this Directive as they challenged the advertising ban. In addition, a separate challenge was being mounted by Japan Tobacco International with regard to its leading brand and registered trademark *'Mild Seven'*, claiming that the EU decision would be an infringement of its intellectual property and a violation of World Trade Organisation rules.[149]

Austria Tabak also had to rename its popular brand and registered trademark *Milde Sorte* ("Mild Sort"), which has been on the market for 40 years, into *Meine Sorte* ("My Sort").[449] However, as in the case of qualifiers such as "light" or "mild", or the imprints of health warnings on cigarette packs, this was only done very recently, after a rebuke from Brussels in September 2003. The blame has been laid upon the paper industry who needed "more time" for the change-over. Yet even in February 2004, according to comments by an Austrian tobacconist, who had constructed his wooden display to cover these "ridiculous" warnings, one could "of course" buy packs without these huge health warnings. A note on the homepage of "tobaccoland"[77], meant for the service of tobacconist shops, points to the "misinformation by the media" concerning the introduction of larger health warning labels and the "long-term transitional agreements".[d] Needless to say, there are as yet no plans for illustrations to accompany the health warnings in Austria. However, simultaneously with the implementation of the health warnings, in autumn 2003 a company in Vorarlberg developed a special container for cigarette packs to cover these warnings. These have not only been a big success in Austria, but have also been exported to other countries.

Public places and workplaces

The limitations of the Treaties mean that the EU cannot legislate directly on smoking in public places. Under the provisions of health and safety at work it is, however, able to legislate against smoking in the workplace. Yet, to date, regulations on smoking in the workplace have been very weak. During the development of the Asbestos Directive in 1983[450], initial but unsuccessful attempts to ban smoking in workplaces were undertaken, followed by three further weak attempts to address public smoking in 1989.[e] Most member states have developed some kind of initiatives. In Austria, a rather weak employee protection law (1994, amended in 1999 and 2001) regulates smoking in the workplace, requiring employers to take measures to protect non-smokers from exposure of tobacco smoke in their workplace "so far as this is possible according to the type of enterprise"[276], but exempts the catering industry *(Chapter 8).* The lack of effective measures in Austria is also reflected in the EU objection of the Austrian government (side to side with Germany) to the Irish Tobacco Law[451], the first national smoking ban within the EU, banning smoking in any workplace including pubs and restaurants.

Compared to the achievements of the United States and Australia to prevent exposure to environmental tobacco smoke (for instance clean indoor air legislation), efforts in Europe can be considered very modest. As smoking in the workplace is closely associated with the general debate on environmental tobacco smoke, the limited efforts so far (both at the European and the national level) reflect both the strenuous opposition from the industry, but also from trade un-

[d] The translation of this note is: "Due to misinformation by the media we inform you that for the new guidelines i) greater warning labels; ii) ban on labelling of "mild", "light" etc.; iii) sale of cigarettes with more than 10mg tar yield, there exist long-term transitional arrangements."

[e] One of these attempts was a non-binding resolution that invited member states to implement policies on smoking in public places, using legislation or other methods. The second was a directive on health and safety at work (Council Directive 89/654/EEC) which required that "in rest rooms and rest areas appropriate measures must be introduced for the protection of non-smokers against the discomfort caused by tobacco smoke".[27] The third was a directive targeted at pregnant or breast-feeding workers, and workers who have recently given birth.

ions, employers, and business representatives.[27] On the other hand, public opinion has shown to be an important motor for pushing towards more smoke-free environments in some countries (for example, some Nordic countries[137]), and surveys such as the 1995 EU survey[405] confirm the support for restrictions by the majority of the public. However, in conference speeches by Pekka Puska of the WHO[186] and David Byrne of the EU[187], an EU-initiative to restrict smoking in the workplace is currently being discussed.

APPENDIX J

Surveys on smoking habits in Austria

National surveys

Smoking habits and health – Microcensus September 1986 *(Statistics Austria)*

The results of the microcensus on smoking habits and health revealed that smoking, dependent on the amount of the consumed tobacco, increases ailments/disorders. Comparing persons who never smoked with daily smokers revealed that smokers complained 1.6 times (male 2.1 times; female 1.3 times) more often about physical disorders than those who never smoked, whereby this difference was higher in younger age groups than in the elderly population. Male smokers complained about chronic difficulties of breathing 4.1 times, female smokers 2.4 times more often than persons of the same sex who never smoked. The risk of chronic breathing difficulties is dependent on the daily amount of cigarette consumption.[11]

Smoking habits – Microcensus December 1997 *(Statistics Austria)*[11]

In December 1997, *Statistics Austria* conducted repeatedly a special microcensus on smoking habits and smoking careers in Austria. In addition, in view of the various anti-smoking activities in Austria over the last decades, a study was carried out by *Statistics Austria* to analyse the development of smoking habits of the Austrian population aged 16 years and over. The analysis was based on the previous microcensus surveys of the years 1972, 1979, 1986 and 1997, revealing trends and developments as well as causes for changes in behaviour.

Following questions on accidents and sports activities, the smoking-related questions are targeted towards status (smoker versus non-smoker), frequency of smoking, smoking articles, amount and intensity of the consumed cigarettes, age of starting smoking, age of possible stopping, motivation or reason for smoking cessation, change of brands, and prevalence of passive smoking. In particular, the questions were as follows:

- Do you smoke? – Daily; Regularly but not daily; Occasionally; No, but smoked in the past; Never smoked.
- Which cigarette brands or other tobacco products do/did you smoke predominantly? (a list was provided, including cigars and pipe)
- How many cigarettes do/did you smoke? – Up to 6 per week; 1-5 daily; 6-10 daily; 11-20 daily; 21-40 daily; More.

Microcensus on Health 1999 and 1991 *(Statistics Austria)*[44 194]

Since 1973, *Statistics Austria* has been conducting regular health surveys in longer intervals. The latest survey focussing on health topics was conducted in September 1999, following the survey of 1991. The aim of this special programme is to get a representative overview of the health situation of the Austrian population aged 15 years and over (private households only). Questions address self-assessment of health status, subjectively felt ailments/medical conditions and diseases, health behaviour and use of health provision services. Smoking behaviour is only one small part of this survey and addressed with only one question:

- Do you smoke cigarettes? – Occasionally; Daily up to 10 cigarettes; Daily 11-20 cigarettes; Daily more than 20 cigarettes; Stopped smoking; Never smoked.

Survey of the Institute of Social Medicine of the University of Vienna (Nicotine Institute)[53]

At the end of the 1990s (no year given), the Austrian Nicotine Institute (associated with the Institute of Social Medicine of the Vienna University) conducted a small survey with 4,975 individuals in Austria aged 15 years and over. The survey, based on a multistage clustered random sample, was conducted in the form of a written questionnaire to be completed by the respondents themselves. The aim of the survey was the assessment of the market or the demand for measures on smoking cessation in Austria. It consisted of four questions, one of them addressing the smoker's attitude towards smoking, that is, if they had a wish to stop or reduce smoking or not.

- Are you a smoker?
- How many cigarettes do you smoke daily on an average?
- Do you intend to reduce or give up smoking in the near future?
- Did you smoke in the past? If yes, since how many years have you not been smoking?

The smoking rates found in this survey are somewhat higher than those found in the surveys conducted by *Statistics Austria*.[a] Despite the very small sample size, these figures were projected to the whole Austrian population and have been widely used by Austrian health politicians, Austrian media and in international compilations, where they were provided by the heads of the institutes. However, these data cannot be regarded as representative and are therefore not included in the following presentation on smoking prevalence.

Regional surveys on smoking behaviour

Vienna Health and Social Survey 2000/2001 *(City of Vienna)*[46]

4019 face-to-face interviews of the Viennese population aged 16 years and more were conducted in two waves in the winter of 1999/2000 (November to February) and 2000/2001 (December to March), private households only. The questionnaire of the first survey included 142 questions, the second 135 questions. 6 questions are addressing the smoking behaviour of the interviewee and the persons in the household.

Although this survey is less representative than the microcensus of Statistics Austria (which counts about 8,000 interviews for Vienna), its advantage lies in the combination of questions regarding socio-economic and health factors. However, when analysing the results, one has to bear in mind that this survey is not representative to the whole Viennese population. First, interviews were not conducted in institutions, like hospitals, nursing homes, prisons, etc. Second, as in many other surveys of that kind, certain groups of the population (especially the socio-economic weaker groups) are clearly under-represented and therefore might lead to false conclusions.

[a] Smoking prevalence for men 32%, women 26%, total 29%.

Microcensus 1999 (and 1991) – Results on Health in Vienna *(Statistics Austria, analysed by City of Vienna 2002)*[48]

The microcensus data with regard to Vienna were analysed and published by the City of Vienna in 2002. Although only one single question addresses smoking behaviour, correlations with other socio-demographic variables as well as comparisons with 1991 and the whole of Austria could be performed *(see also Microcensus for Austria)*.

Vienna Study on Addictive Drugs *(IFES–Institute for Empirical Studies, 2001)*[51]

The Vienna Study on Addictive Drugs (*Suchtmittelstudie – Monitoring 2001*) is a population survey for Vienna. The *Fonds Soziales Wien* (Social Vienna Fund) commissioned the Institute of Empirical Social Research (IFES) with the implementation of a representative survey of the population of Vienna with regard to addictive drugs – including alcohol, nicotine, sedatives, sleeping tablets, tablets for loosing weight, stimulants and drugs for increasing concentration, cannabis products, ecstasy, amphetamins/speed, opium, heroine, methadone, cocaine, LSD, etc.

The survey was conducted from October to November 2001 by way of oral interviews, based on a random sample of 650 persons aged 15 years and more. This survey is comparable to several previous surveys conducted by IFES. Method and parts of the questionnaire were maintained to guarantee time series and to allow analyses of developments and trends in the consumption of addictive drugs as well as basic patterns of attitudes within the population of Vienna.

Main topics of this survey are consumption of addictive drugs in the population, risk assessment, risk sensibility, attitudes towards addictive drugs, estimation of extension of addiction in Austria, handling with drug-consumers among friends, fears of being confronted with drug addiction, supportive measures against drug addiction, addictive drugs as a topic of conversation, etc.

Survey: Life in Vienna *(IFES–Institute for Empirical Studies, 1995)*[52]

This mega-survey with 8,000 face-to-face interviews and a questionnaire comprising 180 questions is looking at all kinds of aspects of life in Vienna, such as living, traffic, health, social conditions, use of institutions, leisure activities, etc.

Only one question, however, addresses the smoking status ("Are you a regular, occasional or non-smoker?"), and it is being correlated with age, sex, education, occupation, family-type, income, district, expectancy for the future (optimist, pessimist, few changes), satisfaction with house/flat.

The survey was repeated in 2003 with about 8,000 telephone interviews and 117 questions (excluding demographic questions). However, some questions – among others also the question on smoking – will only be addressed at 4,000 interviewees.

APPENDIX K

Patterns of smoking in Austria

Smoking rates in Austria

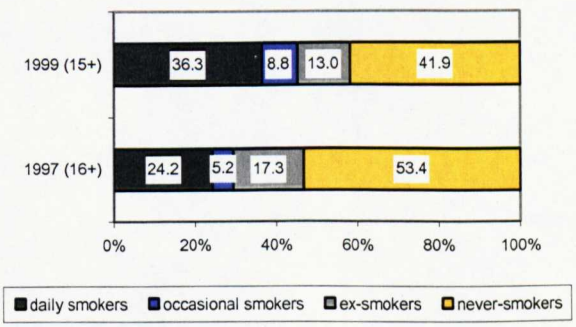
Extrapolating the microcensus on smoking habits (smoking survey), conducted in December 1997, it was projected that 1.89 million persons in Austria aged 16 years and over smoked, and the majority (1.56 million) smoked daily. This represents a smoking prevalence of nearly one third (29.3%) of the total Austrian population aged 16 years and over, and about one quarter of the population (24.2%, or 82.3% of the smokers) smoking on a daily basis. The vast majority of smokers smoked cigarettes; only 1.9% of all smokers smoked pipes or cigars. One in ten respondents (i.e. roughly one quarter of the daily smokers) would be considered a heavy smoker – i.e. 20 or more cigarettes per day. The over 70% of the non-smoking population were made up by 53.4% that were never-smokers and 17% that were ex-smokers.

In contrast, the latest microcensus on health, conducted two years later in September 1999 and including one question on smoking status, yielded prevalences that were somewhat higher than in the 1997 smoking survey. According to this survey, the proportion of smokers in Austria aged 15 years and over was 45.1%. Of these, four out of five (or 36.3% of the total population) smoked on a daily basis. Nearly 42% were never-smokers and 13% were ex-smokers.

As noted above, these different results must not be interpreted as a dramatic increase in smoking prevalence over these two years, but as two contrasting results of two surveys with significant methodological differences whereby the data from the 1997 survey are more reliable. Trends over time are discussed later.

Similarly, the proportion of smokers who have stopped smoking differs between these two surveys. According to the 1997 smoking survey, 17.3% of Austria's population were ex-smokers, corresponding to a quit rate of 37.1%. More than half (53.4%) of the interviewees had never smoked. For comparison, according to the 1999 survey, 13% of Austria's population were ex-smokers and 42% had never smoked. Figure K-1 displays the differences in the results from these two surveys; again, it should be noted that this should not be interpreted as showing increasing prevalence.

Figure K-1 Smoking status in Austria in two different surveys, 1997* and 1999 (in percent)**



* 1997 – Microcensus on smoking habits 1997; 60,000 interviewees aged 16 years and over.

** 1999 – Microcensus on health 1999; 60,000 interviewees aged 15 years and over.

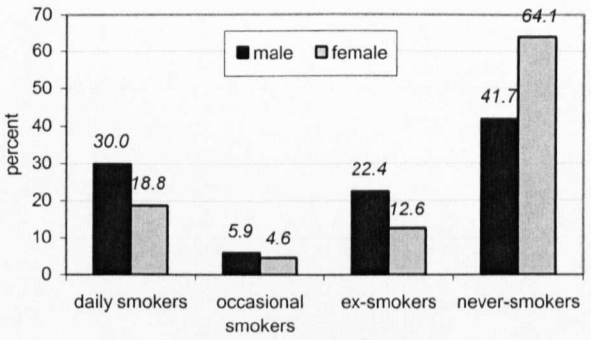
Source: Microcensus 1997 (Statistics Austria)[11]; Microcensus 1999 (Statistics Austria)[44].

The following sections explore these data in more depth, examining how patterns of smoking differ with regard to gender, age, family status, educational level, employment status, and region.

Smoking by gender

As in other countries, Austrian men smoke more frequently than women; they also represent a higher share of ex-smokers. The 1997 survey found that 35.9% of men and 23.3% of women smoked. The proportion of daily smokers was 30.0% for men and 18.8% for women. Just under a quarter of men (22.4%) and one in eight women (12.6%) had stopped smoking (ex-smokers). More than 40% (41.7%) of men and nearly two thirds (64.1%) of women had never smoked (never-smokers) *(Figure K-2)*.[11 a]

Figure K-2 Smoking status and frequency of smoking in Austria in 1997* (by sex, in percent)



* 60,000 interviewees aged 16 years and over.

Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Men also smoked more heavily than women. According to the 1997 smoking survey, 30.0% of men and 18.8% of women are daily smokers (i.e. 83.6% of male smokers and 80.5% of female smokers). 17.1% of men and 4.2% of women were heavy smokers (more than 20 cigarettes per day), i.e. 28.6% of all daily smoking men and 14.2% of daily smoking women. The majority of daily smokers (50.8% of men and 47.7% of women) smoked between 11 and 20 cigarettes per day.[11 b]

For comparison, the results of both surveys are shown in Table K-1.

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[a] The 1999 survey reported the proportion of smokers to be even higher. Almost half of the male population (49.9%) and more than 40% (40.6%) of the female population were reported to smoke at least occasionally; 40.7% of men and 32.1% of women were smoking daily. Accordingly, the proportion of ex-smokers (men 17.4%, women 9.0%) and never-smokers (men 32.7%, women 50.4%) was smaller than indicated in the 1997 survey.[194] Again, however, it must be pointed out that these results do not represent a trend over time, but different results from different surveys with different questions and different statistical methods of weighting the results.

[b] The 1999 survey reported the proportion of daily smokers to be 40.7% in men with 7.6% of Austrian men smoking more than 20 cigarettes per day. The proportion of women who smoked daily was 32.1%, and 2.6% of the female respondents smoked more than 20 cigarettes per day.[194]

Table K-1 Smoking status and frequency of smoking in Austria by two different surveys, 1997* and 1999**

Smoking status and frequency	1997			1999		
	Male	female	total	male	Female	total
	in %					
Daily smokers	*30.0*	*18.8*	*24.2*	*40.7*	*32.1*	*36.3*
Occasional smokers	*5.9*	*4.6*	*5.2*	*9.2*	*8.5*	*8.8*
Ex-smokers	*22.4*	*12.6*	*17.3*	*17.4*	*9.0*	*13.0*
Never-smokers	*41.7*	*64.1*	*53.4*	*32.7*	*50.4*	*41.9*

* 1997 – Microcensus on smoking habits 1997; 60,000 interviewees aged 16 years and over.

** 1999 – Microcensus on health 1999; 60,000 interviewees aged 15 years and over.

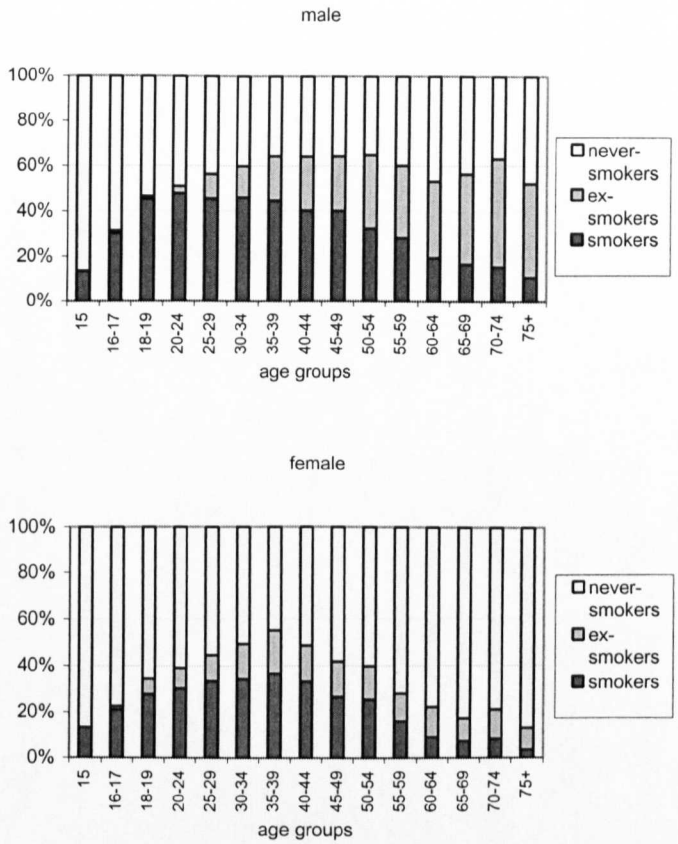
Source: Microcensus 1997 (Statistics Austria)[11]; Microcensus 1999 (Statistics Austria)[44].

Patterns of smoking by age

Smoking in Austria is already common at young ages. In many countries, the median age of initiation is typically under 15 years.[10] In the 1997 survey, one in seven girls and boys aged 15 years smoked (boys 13.5%, girls 13.4%), but more girls than boys smoked every day (girls 9.9%, boys 5.9%). For 16 to 17 year olds, approximately one in three boys and one in five girls smoked. Nearly half of young Austrian males, aged 18 to 19 years old (45.3%) and more than one quarter of the females in this age group (27.8%), smoked *(see later)*.[11]

Of all age groups, the highest rate of smoking was found among young male adults aged 20 to 24 years (47.9%) *(Figure K-3)*. However, while smoking becomes less common with age among men, the proportion of female smokers increases until the age of 35 to 39 years (36.7%) before decreasing. Very low smoking rates are found in the older age groups, for both men and women. Among 60 to 64 year old men only 19.4% smoked, and in the age group of 75 years and over it has fallen by almost half (10.8%). Among 60 to 64 year old women 9.2% are smokers, although there is only a slight decrease to 8.5% for women aged 75 years and over.[11]

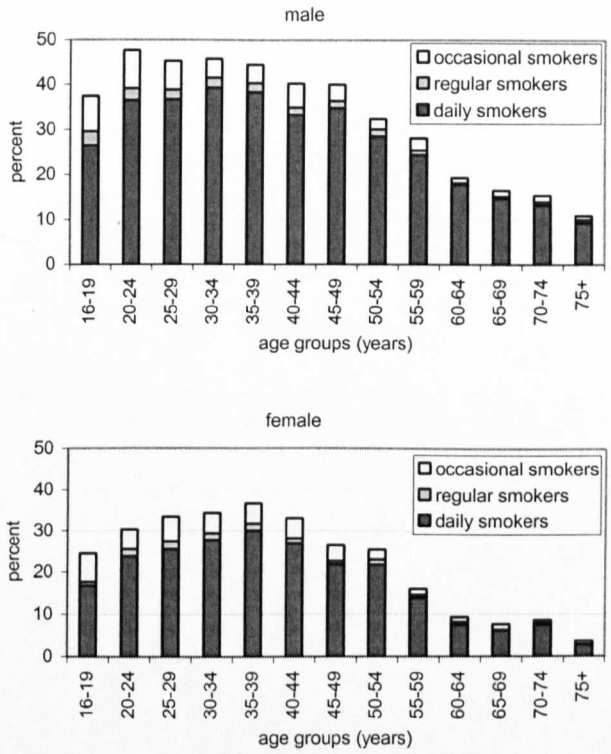
Figure K-3 Smoking status, 15 years and over, by age and sex, Austria 1997



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

The smoking status is partly reflected in the frequency of smoking. Daily smoking is already very high among young men 16 to 19 years old but increases further sharply in the following age group 20 to 24 years, before reaching the peak at 30 to 34 years. Daily smoking rates among men only start to decrease at age 50. Among women, daily smoking increases continuously until reaching the peak at age 35 to 39. A marked decrease in daily female smoking rates can only be observed from age 55 onwards *(Figure K-4)*.

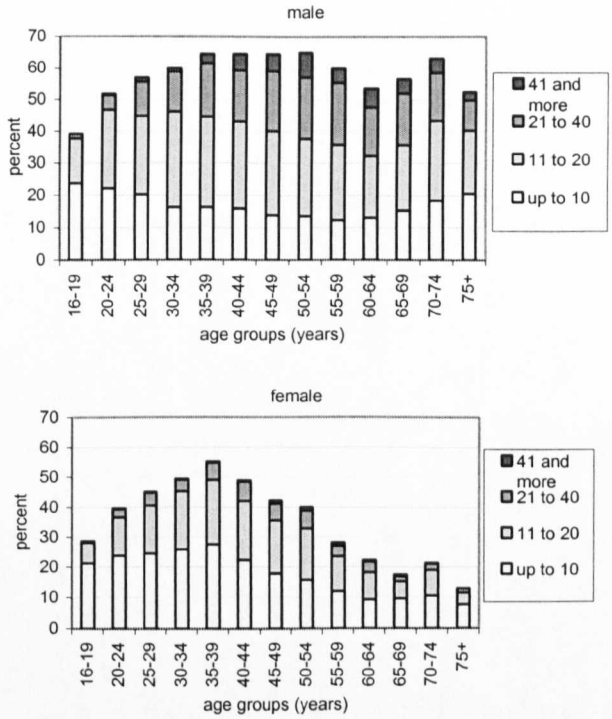
Figure K-4 Smoking frequency, 16 years and over, by age and sex, Austria 1997



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Turning to intensity of smoking, the proportion of heavy smokers (20 cigarettes and more) increases until middle age, with the peak age group being 50 to 54 where the figure for men is almost four times that for women (27.2% vs. 7.2%), before it slowly decreases again. Although is likely to be due, at least in part, to selective survival of non-smokers. In the 75 years and over age group, only 12.1% of men and 1.4% of women are heavy smokers *(Figure K-5)*.

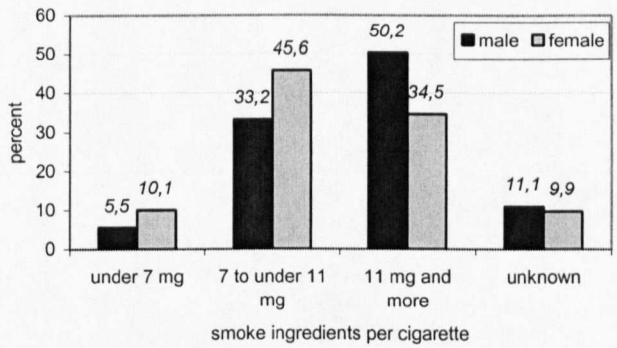
Figure K-5 Smoking intensity: cigarettes per day, by age and sex, Austria 1997



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

However, it is not only the quantity, but also the strength of cigarettes that varies by sex and age among daily smokers. In all age groups, women are more likely to smoke low-tar cigarettes than men *(Figure K-6)*.

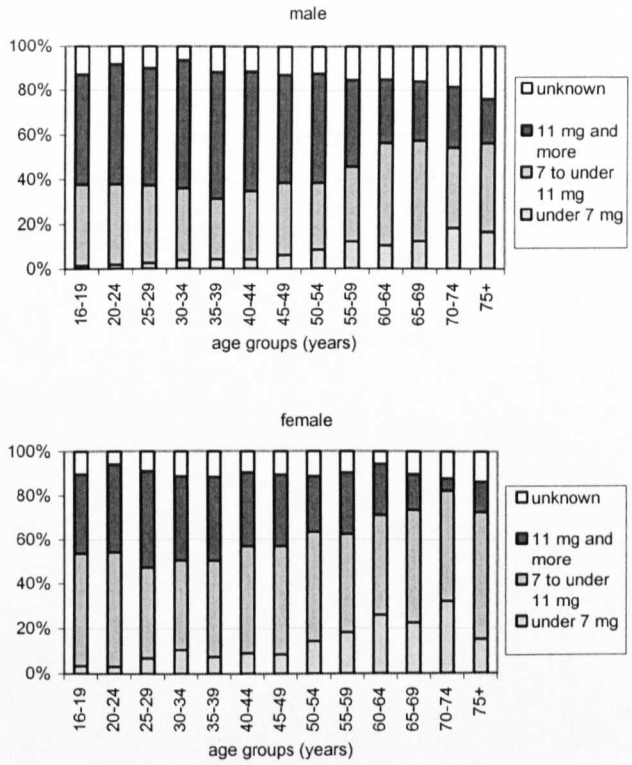
Figure K-6 Potency (tar yield) of cigarettes of daily smokers, Austria 1997 (by sex, in percent)



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

In the 1997 survey, nearly half of young males smoking daily (49.5%) and more than one third of young females smoking daily (36.0%) in the 16 to 19 age group were smoking regular or strong cigarettes with a tar yield of 11mg or more *(Figure K-7)*. The groups containing the highest proportion of "full flavoured" cigarette smokers are middle-aged men (30 to 39 years), where the proportion is 57-58% and women aged 25 to 29 years with a proportion of 44% of the daily smokers.[11] Thus while women are choosing lighter cigarettes from the age of 30 years onwards, and indeed are known to be the main targets of misleading advertising using the terms 'light' or 'mild' cigarettes[27], men do so only at a later age, from 40 years onwards.

Figure K-7 Potency (tar yield) of cigarette smoking by age and sex, Austria 1997



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Children and adolescents

As in other western European countries, smoking among adolescents in Austria is increasing, despite growing knowledge about its adverse effects and also despite various youth-oriented health campaigns. However, this increase appears to be driven by female smoking rates, which are increasing substantially, while male smoking rates appear stagnant.

Results for 15 year olds from the 1997 microcensus on smoking habits and the WHO HBSC study differ noticeably. While according to the microcensus, about 13.5% of the boys and girls are smokers[11], the HBSC study reported that 20% of boys and 25% of girls in Austria smoke daily. Of all countries included in the study, the highest percentages were found in Austria, France, and Germany; the lowest in Portugal, Greece, and Sweden.[12] As in the microcensus, more girls than boys reported smoking daily in Austria, a finding replicated in most other countries.

The two surveys, however, have important differences in study design. While the microcensus is based on oral interviews with all young people independent of their status and with detailed training of the interviewers, the WHO study is based on a written survey of school students where questionnaires were distributed and completed in class rooms, anonymously, but still in the presence of others. Thus the scale of smoking may be overestimated in the HBSC survey because of a tendency towards conformity within the peer group, while in the case of the microcensus, the frequent use of others (mostly parents) as informants, or their presence during the interview, may have resulted in an underestimation of the prevalence of smoking.[11]

The HBSC study identifies a clear gender distinction in trends in teenage smoking over the last decade in many countries. While tobacco consumption among boys has declined, the opposite is true for girls – daily smoking among 15 year-old girls is more frequent than among their male counterparts. Of 28 countries, including Europe, USA, Canada, Russia, Greenland and Israel, Austrian teenagers are in top positions with regard to alcohol consumption and cigarette smoking. One in four girls and one in five boys aged 15 years smoke daily, placing Austria in fifth place regarding teenage smoking.[12 13] The study also documents a correlation between cigarette smoking and alcohol consumption.

There are many factors that may influence an adolescent to initiate smoking; these include ethnicity, socioeconomic status, family structure, advertising, and physical and emotional abuse, but also the smoking behaviour of parents, siblings and peers.[452 453] In particular, family and peers are reported to have a high influence on smoking initiation of adolescents. Bobo & Husten report that if parents, siblings or peers smoke, an adolescent is not only more likely to start smoking but will also do so at an earlier age.[454] Some authors even rank peer influence higher than parental influence.[455] Youths who belong to a peer group or often attend to parties show a higher affinity to smoking than others.[456 457] This peer effect applies even more to girls than to boys.[458] Similar results are reported by Molyneux *et al.* who found that incident smoking among adolescents occurred significantly more often in girls and in students with parents or siblings who smoke.[459] The authors even equate to some extent incidence smoking in adolescents to a communicable disorder which may be, at least partly, preventable by policies that reduce exposure to smoking at school.[460] In addition, the situation at and perception of school (pressure to perform, happiness, etc.) has been found to play an influential factor on the smoking behaviour of children and adolescents.[192] These early developments continue to be of importance in later life. The earlier smoking is started, the higher is the probability of continuing smoking in adult age.[461] Importantly, the CDC report on Incidence of Initiation of Cigarette Smoking[462] found that of the 89% who initiate smoking in their teens, 71% become daily smokers by the time they are 18 years old. This shows the extent of vulnerability of youth – and the reason, why young people are one of the main targets for tobacco advertising.

Despite increased health awareness among teenagers, the dangers that can result from smoking are played down or repressed. This has to be seen in connection with the main motives for cigarette smoking among young people. Smoking is often seen as a symbolic sign of affiliation, a marker of transition (symbol of initiation or rite of passage), a method of compensation for other perceived weaknesses, and/or a lifestyle element (the image promoted by advertising).[463] It is, however, important to be aware how smoking can have different individual and social functions for boys and girls.

A recent European report on gender differences in smoking in young people, based on the HBSC data, puts Austrian 14-16 year olds in top position among the five countries studied (Austria, Belgium, Poland, Scotland, Sweden) with regard to regular smoking, with Austrian girls leading by far.[464]

Cohort effects

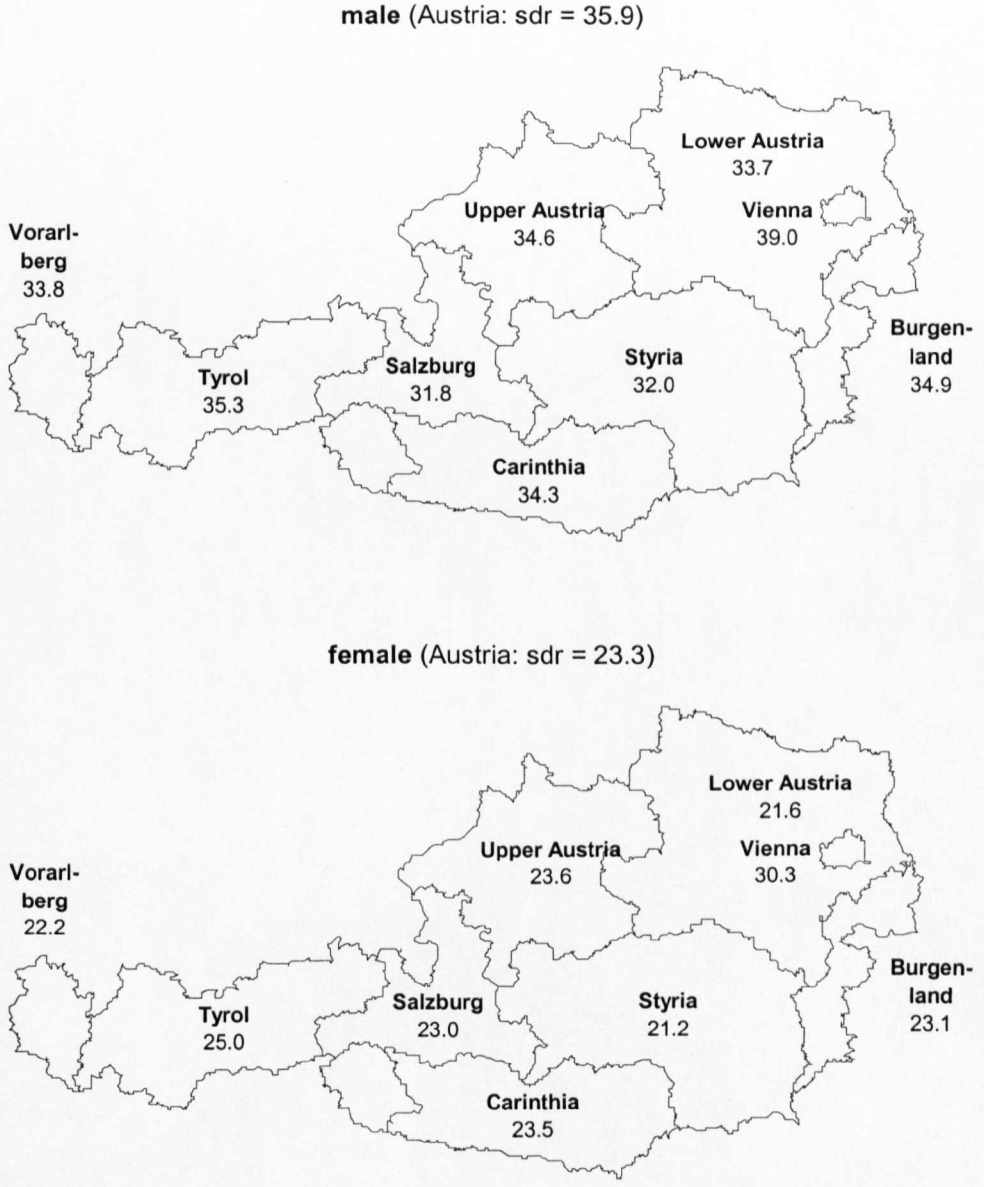
Observed patterns of smoking are heavily influenced by cohort effects. This is apparent in the high non-smoking figures among those reaching adulthood in the immediate post-war period, for whom smoking was often unaffordable. In contrast, in the 1997 survey, women aged about 35 to 39 years not only had the highest proportion of smokers (36.7%), but also of ex-smokers (18.5%). This group represents the cohort born in 1958 to 1962. Assuming that smoking at that

time was taken up at the age of about 16 to 18, we can observe the cohort effect of the mid-to-end-seventies *(Chapter 7)*.

Regional differences

Particularly for women, but also to some degree for men, smoking is more common in urban than in rural areas. In Vienna, for example, smoking in general and among young people in particular is more common than in other parts of Austria. Regional differences among the nine federal provinces of Austria are shown in Figure K-8.

Figure K-8 Regional differences in smoking rates in Austria, 1997, by sex (age-standardised rates*



* Direct age-standardisation using all surveyed persons of the December 1997 Microcensus as the standard population.

Source: *Microcensus on smoking behaviour 1997 (Statistics Austria).*[11]

In addition, Vienna has the highest proportion of heavy smokers. In the 1997 survey, more than one in three of men smoking daily (34.1%) and nearly one in five of women smoking daily (19.4%) smoked more than 20 cigarettes per day. The lowest proportions of heavy smokers are found in Vorarlberg, Carinthia, Burgenland and Salzburg.

Male cigar smokers can mainly be found in the western provinces (Tyrol and Vorarlberg), female cigar smokers in Salzburg. The highest proportion of male pipe smokers was found in Tyrol and Lower Austria, the highest proportion of female pipe smokers in Vorarlberg.

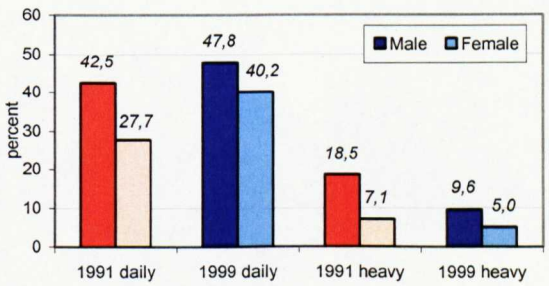
There is also a clear relationship between the contribution of agriculture to the region's economy and the frequency of smoking. The lower the contribution of agriculture, the more frequent is smoking and the lower is the proportion of those who have never smoked. Regional differences are higher among women than men.[11]

Smoking in Vienna

In the 1999 microcensus, which was separately analysed for Vienna[48], more than half of the population in Vienna aged 15 years and over (51.7%) smoked, at least occasionally; 43.8% of Viennese smoke daily. This places Vienna markedly above the Austrian average, as reported in the 1999 microcensus analysed for the whole of Austria (45.1% of the Austrian population smoke at least occasionally and 36.8% smoke daily). Likewise, the proportion of heavy smokers (more than 20 cigarettes per day) is above average in Vienna (7.2%, compared to 5.0% for all of Austria).

Using the 1991 and 1999 microcensus with a single smoking question, an apparent dramatic increase in female daily smokers of 45% can be observed in Vienna *(Figure K-9)*, while the increase among men was only 12.5%.[c 48] In 1999, 47.8% of Viennese men and 40.2% of Viennese women were daily smokers. However, 'only' 9.6% of men and 5.0% of women are heavy smokers, indicating a marked decrease in heavy smoking since 1991 – especially in men, who exhibit a reduction of 50%, and within the age group of 30 to 44 year olds. There has also been an increase of daily smoking among teenagers and young adults, especially in women.[44]

Figure K-9 Smoking in Vienna in 1991 and 1999, in percent (by sex)

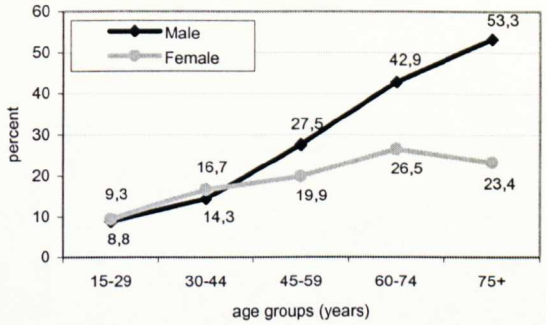


Source: Microcensus 1999 (City of Vienna).[48]

[c] Due to the use of different questions, the results of the microcensus 1991 and the microcensus 1999 are not directly comparable. In 1991, only daily but not occasional smoking was asked about. Nevertheless, the data indicate the broad development of smoking behaviour in the 1990s. The enormous increase in female smoking rates has led to a marked decrease of the gender differences in Vienna. In parallel with the strongly increasing female smoking rates, an increase in female lung cancer mortality can be observed, while male lung cancer rates remained more or less unchanged *(Chapter 7)*.[48]

The Vienna Study on Addictive Drugs, conducted continuously since 1993 by the Institute for Empirical Studies (IFES) on 650 persons aged 15 years or over, reports that there may even have been a further recent increase in smoking in Vienna between 1999 and 2001.[51] Likewise, the quit rate in Vienna is slightly lower than that for the whole of Austria (20.1% vs. 22.4%). The data from the 1999 microcensus suggest that the tendency to give up smoking increases more markedly with age among men than women *(Figure K-10)*. This issue is examined in more detail later.

Figure K-10 Quit rate in Vienna and in Austria in 1999, in percent (by sex)



Source: Microcensus 1999 (City of Vienna).[48]

Socio-economic determinants

In developed countries it is now a common finding that members of higher social strata smoke less than those in lower social strata. In Austria, however, this assumption cannot wholly be confirmed as yet.[11] Although men with the highest educational level (university degree) indeed have the lowest smoking rates, due both to the high proportion of ex-smokers and never-smokers, and men with the lowest educational levels had the highest rates of smokers and an above-average proportion of ex-smokers, hardly any differences could be identified for the other groups in between. Women showed a strong polarisation in the lower educational groups and no obvious differences could be found in university graduates.

With regard to employment status, reported results indicate that self-employed persons smoke less than employees. Among the latter, the probability of smoking decreases in the following order: blue-collar workers, skilled workers, white-collar employees, and civil servants. Especially high rates of smoking are found among unemployed persons.

In summary, we can observe that with increasing education, male smoking rates decrease in all age groups, while female smoking rates show this correlation only in the younger age groups. However, individuals of a higher educational level, tend to smoke lighter cigarettes. Smoking rates for unemployed men and women are conspicuously high.

With regard to marital status, divorced persons are the most frequent smokers and the share of heavy smokers in this group is above average. While married persons are more likely to stop smoking, both more frequently and at an earlier age, the proportion of ex-smokers in single people only increases in the higher age groups.[11]

More detailed data on socio-economic determinants of smoking has been obtained by the recent Vienna Health and Social Survey, carried out in the winter months of 1999/2000 and

2000/2001. Participants were randomly selected and the response rate was 55% (4,019 / 7,300). Face-to-face interviews took place in the household of the interviewee. In the published study, analyses took account of the weighted sample (according to the most recent Microcensus data published by *Statistics Austria*). Adjusted estimates were for sex, age, education, employment, citizenship, district, size of household, and marital status, stratified by sex and age. The authors performed linear regression in some cases (but not with regard to smoking), adjusting for age, income and education, stratified by sex.[46] A more general description of the survey can be found in APPENDIX J.

According to this survey, the most influential social determinants of smoking were age and education. While most smokers are male, results indicate that women are increasingly taking up smoking, especially in younger age groups. There are, however, differences according to the level of education. The daily smoking rate in lower educated men (compulsory schooling or an apprenticeship as their highest level of education) is 58%, compared to 23% for men with a university degree; lower educated women show a smoking rate of 32%, compared to 16% in women with a university degree.[46]

Income seems also to be correlated with smoking patterns but it is strongly associated with education. The Vienna survey found that men living in households where the net income was less than €730 per household member per month had significantly higher smoking rates than others (48% compared to only 39% for men with an income over €1,900). Although female smoking rates are generally lower than those of males, the same pattern can be detected here (smoking rate of 35% for women with less than €730 compared to 24% for women with more than €1,900 monthly net household income per household member). Although women with the lowest incomes have the highest smoking rates across all age groups, income becomes especially important from age 25 onwards. The highest non-smoking rates are found in women with a household income of more than €1,900 per person and per month; this seems, however, due to an effect of age as it concerns particularly women aged 60 years and over.[47]

Unemployment in particular plays a key role in smoking behaviour, especially in men. While the smoking rate among gainfully employed persons is 32% (for both male and female), it rises to 46% in those who experienced unemployment during the last three years[d]. Most of the effect of other variables that have been associated with smoking behaviour – such as job position, area of residence, or ethnic origin – appear to be attributable to education. Similarly, low job satisfaction, low satisfaction with living conditions, and a low or only medium self-reported quality of life often seem to be a result of low income due to a lower level of education, rather than influential factors on their own. Higher smoking rates were found among those who report a high number of incisive life events – such as the experience of a serious disease or an emotional crisis.[e] However, the published data only offer unadjusted estimates.[47] Another finding of the survey is that daily smoking is associated with perceived stress. While among men who do not feel particularly stressed the proportion of daily smokers is 35%, the proportion increases to 50% among men who feel often stressed. Among women the corresponding percentages for daily smoking are 25% and 38%, but they also show a more marked increase in occasional smoking when feeling often under stress.[49]

[d] Regardless if once or more often for a short while, or continuously for the whole period of three years.

[e] Incisive life events are listed as the experience of a serious disease in oneself or a close person, an emotional crisis, the death of a close person, having a victim of crime within one's own family, having been involved in a law suit or trial, the experience of loss of someone beloved or something precious, high financial strains, a quarrel with a close acquaintance or suffering from the ending of an important relationship, suffering from a severe insult, disappointment or injustice.

The published results confirm that the average age of taking up smoking has changed dramatically over recent decades, with a clear shift towards younger age groups in both sexes. While men now aged 75 years and over report having started smoking at a mean age of 20.2 years and men aged 60 to 74 years at an age of about 19 years, young men now aged 16 to 24 years already started smoking at the age of 15.1 years and men aged 25 to 44 years at the age of 17.1 years on average. In women, this tendency is even more marked, with a starting age of 15.2 years in 16 to 24 year olds and 17.4 years in 25 to 44 year olds, respectively, compared to a starting age of 21 years in 60 to 74 year old women and 23.4 years in women aged 75 years and over.[46] Obviously, in the very youngest age bands, these figures need to be interpreted in the knowledge that they may contain some people who will become smokers but who have not yet commenced, so the apparent reduction of about 2 years in the age starting smoking in recent years is likely to be an overestimate.

The 45 to 59 age group contains the heaviest smokers. Thus, Viennese men of this age smoke on average 26 cigarettes per day and women 20.5. In men, the second-largest group of heavy smokers is 25 to 44 years old, with an average consumption of 21.5 cigarettes per day. In addition, those who have undergone an apprenticeship are the heaviest smokers (male smokers 23.4 cigarettes, female smokers 20.5 cigarettes per day), while cigarette consumption is lowest among smokers with a university degree (men 19.2, women 14.8 cigarettes per day).[46]

The highest percentages reporting that they had made any attempts to give up smoking or to reduce tobacco consumption over the last year, were found in the youngest age group in both sexes, as well as in men aged 75 years and over.[46]

Explanatory power of the published data of the Vienna Health and Social Survey was very limited with regard to smoking patterns, in particular due to the lack of adjustment for co-variates. However, access to the raw data allowed further analysis. Data were adjusted for the factors that appear to have the strongest influence: age, employment and education *(Chapter 2; 2.2.3)*.

Logistic regression confirmed that age is a highly significant determinant of smoking in both sexes *($p<0.0001$)*, with smoking rates decreasing dramatically with age. When unadjusted for age, education is highly significant in men, but in women only with regard to the highest educational level. In the same way, unemployment is highly significant in men, and nationality very significant in both sexes, but more so in men.

When adjusted for age, education remains highly significant in men, with a decreasing odds ratio in men across educational categories. Thus, those having a university degree exhibited an odds of 0.24 relative to those with only compulsory schooling), but for women the difference is only significant at the highest educational level (women with university degree smoke significantly less than all others, *$OR=0.39$*). The importance of adjustment becomes apparent in the case of income. Although in the initial reports, smoking rates seemed to decrease with rising income (especially in higher income groups), these differences disappear completely after adjusting for age. The same holds true for nationality: While Austrian citizens appear to smoke less than others, this is accounted for by age and education. This is not entirely surprising given that over 80 percent of foreign citizens are immigrant workers from former Yugoslavia or Turkey, mostly with a very low level of education and younger than 45 years of age.

However, having been unemployed during the past three years *(Footnote d above)* significantly influences smoking behaviour, especially in men. After adjusting for age and even after fully adjusting for age, nationality, income, and education, the results are still highly significant for unemployed men – meaning that men with experience of unemployment over the last three years are more than one-and-half times more likely to smoke than those who were employed

throughout this period; fully adjusted values (OR 1.55, CI 1.17-2.05; p=0.002). In contrast, for unemployed women, adjusted estimates were not significant (OR 1.01, CI 0.72-1.41; p=0.97).

Similarly, only in men, education proved to be highly significant ($p<0.0001$). In women, only those with university degree show significantly lower smoking rates.

In summary, we find that age and, in men, education and unemployment are the driving forces of smoking behaviour.

Table K-2 Odds of smoking, unadjusted and adjusted for age, education and employment, Vienna 2000/2001

Variable	Male							Female						
	Frequ.	Unadjusted		Adjusted for age		Fully adjusted		Frequ.	Unadjusted		Adjusted for age		Fully adjusted	
	N	OR	95% C.I.	OR	95% C.I.	OR	95% C.I.	N	OR	95% C.I.	OR	95% C.I.	OR	95% C.I.
Age			*p<0.0001*				*p<0.0001*			*p<0.0001*				*p<0.0001*
16-24 yrs	361	1.00	-			1.00		323	1.00	-			1.00	-
25-44 yrs	836	**0.70**	**0.55-0.90**			0.76		744	**0.46**	**0.35-0.60**			**0.35**	**0.22-0.56**
45-59 yrs	454	**0.58**	**0.44-0.76**			0.57		415	**0.51**	**0.38-0.69**			**0.31**	**0.19-0.51**
60-74 yrs	287	**0.24**	**0.17-0.34**			0.24		312	**0.28**	**0.20-0.40**			**0.16**	**0.09-0.27**
75+ yrs	110	**0.09**	**0.04-0.17**			0.10		177	**0.08**	**0.04-0.15**			**0.05**	**0.02-0.11**
Nationality			*p<0.0001*		*p=0.129*		*p=0.92*			*p=0.009*		*p=0.446*		*p=0.30*
Austrian	1,705	1.00	-	1.00		1.00		1,647	1.00	-	1.00	-	1.00	
Other	248	**1.81**	**1.39-2.37**	0.80	0.61-1.07	1.02	0.69-1.52	236	**1.46**	**1.10-1.94**	1.13	0.83-1.54	0.78	0.49-1.25
Income [1]			*P=0.027*		*p=0.50*		*p=0.34*			*p=0.039*		*p=0.27*		*p=0.37*
< €730	268	1.00	-	1.00	-	1.00		306	1.00	-	1.00	-	1.00	-
€730 – < €1,310	651	0.78	0.58-1.03	1.06	0.72-1.55	0.86	0.60-1.24	683	0.77	0.58-1.02	**1.68**	**1.00-2.80**	0.75	0.52-1.08
€1,310 – < €2,200	594	**0.65**	**0.49-0.87**	1.04	0.75-1,44	0.89	0.61-1.30	510	0.76	0.57-1.03	1.47	0.91-2.38	0.76	0.51-1.13
> €2,200	222	**0.66**	**0.46-0.95**	0.88	0.63-1.22	1.17	0.75-1.85	116	**0.50**	**0.31-0.82**	1.42	0.88-2.31	0.64	0.35-1.15
Employment			*P<0.0001*		*p<0.0001*		*p=0.002*			*p=0.002*		*p=0.31*		*p=0.97*
Yes	1,455	1.00	-	1.00	-	1.00	-	1,391	1.00	-	1.00	-	1.00	
No	366	**2.05**	**1.62-2.59**	**1.63**	**1.28-2.06**	**1.55**	**1.17-2.05**	256	**1.54**	**1.17-2.04**	1.16	0.87-1.56	1.01	0.72-1.41
Education			*p<0.0001*		*p<0.0001*		*p<0.0001*			*p<0.0001*		*p=0.001*		*p=0.001*
Compulsory schooling	356	1.00	-	1.00	-	1.00	-	459	1.00	-	1.00	-	1.00	-
Apprenticeship	617	**0.54**	**0.42-0.71**	**0.69**	**0.32-0.93**	**0.53**	**0.37-0.77**	370	0.91	0.68-1.22	1.06	0.78-1.45	0.82	0.56-1.19
Secondary schooling	834	**0.41**	**0.32-0.53**	**0.46**	**0.35-0.61**	**0.36**	**0.25-0.53**	955	0.81	0.64-1.03	0.84	0.65-1.08	**0.65**	**0.46-0.91**
University degree	241	**0.24**	**0.17-0.34**	**0.25**	**0.17-0.38**	**0.21**	**0.13-0.34**	187	**0.38**	**0.25-0.58**	**0.38**	**0.25-0.60**	**0.22**	**0.12-0.40**

1) Household income (net) per month per household member.

Source: Logistic Regression performed on data from the Vienna Health and Social Survey 2000/200.[46]

Time series analysis

Although, as already noted, time series of smoking behaviour in Austria is problematic due to the use of different questions, survey and sampling techniques, with caution, certain trends can be inferred from those surveys with specific sections on smoking. As in other countries, tobacco consumption has developed differently in men and women over recent decades. While smoking seems to be becoming less common among men, smoking rates in women have increased. Since 1986, however, the proportion of daily smokers has been declining in both men and women, accompanied by a trend towards lighter cigarettes.

Altogether, between 1972 and 1997, the male smoking rate decreased by more than 20% (from 45.3% to 35.9%), while the female smoking rate increased by 78% (from 13.1% to 23.3%). As with men, the proportion of women who have stopped smoking (ex-smokers) increased markedly over that period of time. Accordingly, since 1972, the proportion of never-smokers has been slightly but continuously rising among the male population, while falling significantly among the female population. Nevertheless, the proportion of non-smokers is of course much higher among the female than the male population *(Table K-3 and Table K-4)*.

Table K-3 Smoking status in the Austrian population 15 years and over by sex, 1991 and 1999

Smoking status	1991		1999	
	Male	Female	Male	Female
Respondents in 1,000 (=100%)	2,518.4	2,810.9	3,157.7	3,434.3
Of these smoke (in percent)	***36.2***	***20.8***	***49.9***	***40.6***
occasionally	-	-	*9.2*	*8.5*
daily	*36.2*	*20.8*	*40.7*	*32.1*
daily up to 10 cigarettes	*8.9*	*8.4*	*22.4*	*22.0*
daily 11 to 20 cigarettes	*15.4*	*8.8*	*10.7*	*7.5*
daily more than 20 cigarettes	*11.9*	*3.6*	*7.6*	*2.6*
Ex-smokers	*21.5*	*9.6*	*17.4*	*9.0*
Never-smokers	*42.2*	*69.5*	*32.7*	*50.4*

Source: Microcensus on Health, December 1991 and September 1999 (Statistics Austria).[44]

Table K-4 Development of smoking status in Austria, 1972 to 1997

Smoking status	1972	1979	1986	1997
	Total			
in 1,000 (=100%)	5,345.6	5,559.9	5,719.9	6,445.5
of these *(in percent)* ...				
smokers	*27.7*	*28.1*	*30.1*	*29.3*
Ex-smokers	*11.5*	*12.4*	*12.9*	*17.3*
never-smokers	*60.4*	*57.9*	*54.3*	*53.4*
smoking status unknown	*0.4*	*1.6*	*2.7*	-
Quit rate *(in percent)* [1]	*41.5*	*30.6*	*30.0*	*37.1*
age-standardised rates *(in percent)* [2]				
smokers	-	*28.9*	*30.1*	*29.3*
Ex-smokers	-	*12.7*	*13.4*	*17.3*
never-smokers	-	*56.8*	*53.8*	*53.4*
	Male			
in 1,000 (=100%)	2,409.0	2,548.4	2,680.0	3,085.0
of these *(in percent)* ...				
smokers	*45.3*	*41.1*	*40.0*	*35.9*
Ex-smokers	*19.5*	*19.6*	*18.9*	*22.4*
never-smokers	*34.8*	*37.9*	*38.6*	*41.7*
smoking status unknown	*0.4*	*1.4*	*2.5*	-
Quit rate *(in percent)* [1]	*30.1*	*32.3*	*32.1*	*38.4*
age-standardised rates *(in percent)* [2]				
smokers	-	*41.9*	*40.3*	*35.9*
Ex-smokers	-	*20.1*	*20.0*	*22.4*
never-smokers	-	*36.6*	*37.3*	*41.7*
	Female			
in 1,000 (=100%)	2,920.4	3,011.5	3,039.9	3,360.5
of these *(in percent)* ...				
smokers	*13.1*	*17.1*	*21.3*	*23.3*
Ex-smokers	*4.8*	*6.3*	*7.6*	*12.6*
never-smokers	*81.8*	*74.9*	*68.2*	*64.1*
smoking status unknown	*0.3*	*1.7*	*2.9*	-
Quit rate *(in percent)* [1]	*26.8*	*26.9*	*26.3*	*35.0*
age-standardised rates *(in percent)* [2]				
smokers	-	*17.9*	*21.3*	*23.3*
Ex-smokers	-	*6.7*	*7.8*	*12.6*
never-smokers	-	*73.7*	*68.0*	*64.1*

1) Proportion of ex-smokers of all persons who have ever smoked (smokers and ex-smokers).

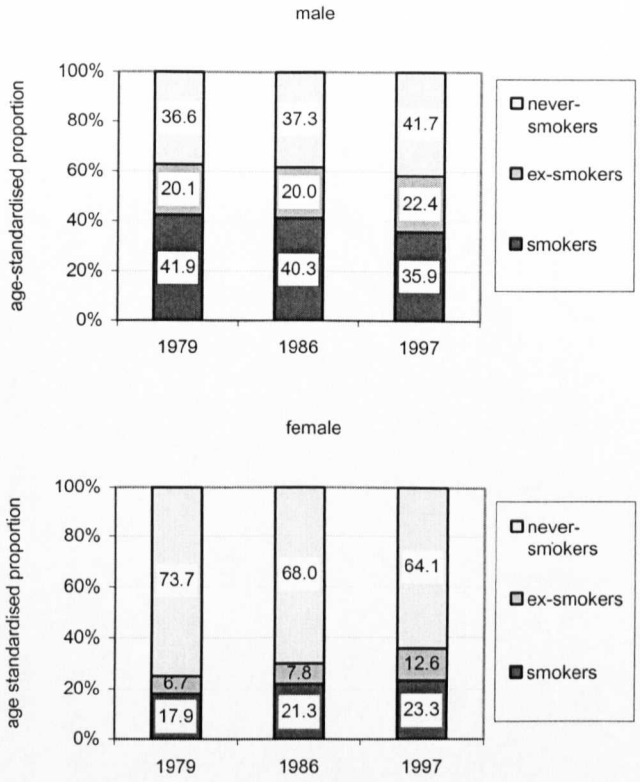
2) Direct age-standardisation using all surveyed persons of the December 1997 Microcensus as the standard population.

Source: Data from the Microcensus 1972, 1979, 1986, 1997 (Statistics Austria).[11]

Crude comparisons do not, however, take account of the age composition of the population. To produce a more valid time series, the influence of age has been eliminated by age standardisation[a] in Figure K-11.

[a] Direct standardisation; the distribution of all persons aged 16 years and over surveyed in the September 1997 microcensus was chosen as standard population.

Figure K-11 Development of smoking status in Austria, 1979 to 1997 (based on age-standardised rates)



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Consistent with increasing smoking rates among women, an increase in lung cancer mortality has been observed in the female Austrian population. Among the male population, lung cancer mortality has remained nearly unchanged in the same period of time *(Chapter 7)*.

Yet while smoking rates continue to increase among Austrian women, at least the rate of increase appears to be slowing. Between 1972 and 1979, female smoking rates increased by roughly 31%, between 1979 and 1986 by 25%, but between 1986 and 1997 they have increased by 'only' 9%. Male smoking rates decreased by roughly 9% between 1972 and 1979, by another 3% between 1979 and 1986, and by 10% between 1986 and 1997.

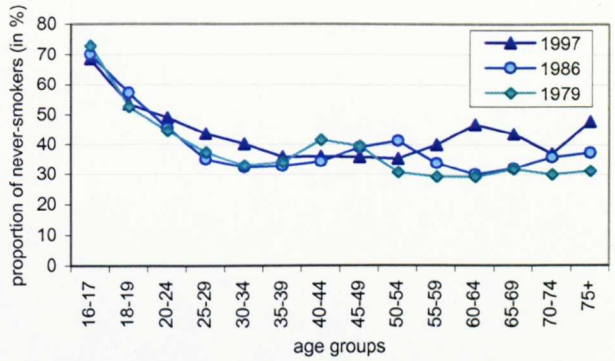
In both sexes, a trend towards lighter cigarettes can be observed. In 1979, more than half of men smoking daily (56.3%) and more than one third of women smoking daily (36.7%) smoked cigarettes with a tar level of more than 15mg. Since December 1997, no cigarettes with more than 12mg of tar have been available on the Austrian tobacco market. Partly as a consequence of this, 38% of male smokers and 55% of female smokers were smoking "low" yield cigarettes with less than 10mg of tar in 1997, compared to 29% (men) and 42% (women) in 1986. However, the trend towards lighter cigarettes cannot be attributed to a change in behaviour of smokers, but rather to the reduction of tar in popular brands, initiated by legislation, and the lower price of lower tar yield cigarettes.

Similarly, the increase in the number of cigarettes smoked by daily smokers, observable until 1986, has now stopped. Young people of both sexes, however, smoke more frequently. While elderly men (50 years and over), in particular, are reported to smoke less since 1979, young

male smokers (16 to 19 years) have increased their consumption. In contrast to the trends in the male population, an increase in female smoking rates can be observed in nearly all age groups.

The striking shift in the peak in frequency of never-smokers recorded in successive surveys (1979 age group 40-49 years; 1986 age group 45-54 years; 1997 age group 55-69 years) is illustrated in Figure K-12. It can be attributed to the birth cohort of about 1928 to 1940, when the age of taking up smoking fell as they reached adolescence in the post-war years. As most of the then young people could not afford tobacco products, it is assumed that this cohort was more likely to be abstinent in that crucial period and did not take up smoking in later years *(APPENDIX R)*. A similar phenomenon has been reported in Russia.[465]

Figure K-12 Proportion of never-smokers, Austria 1979–1997

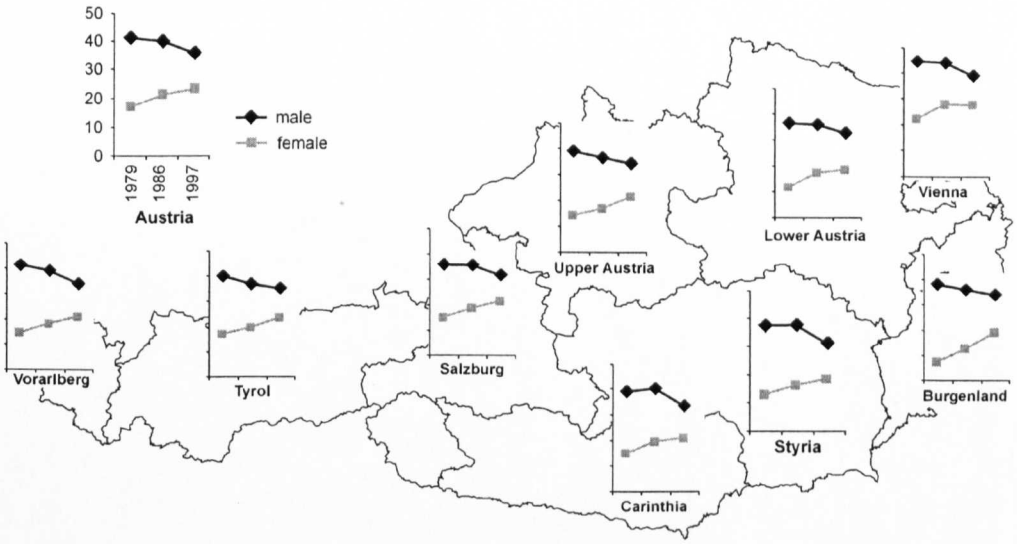


Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Turning to regional differences in trends in smoking rates *(Figure K-13)*, an increase is observable among men in nearly all provinces until 1986 (except for the Burgenland, Upper Austria and Tyrol), followed by a decrease that lasts until the present day. The greatest increase since 1979 can be observed in the Burgenland, which in the past (before 1986) had the lowest smoking rates of all provinces.

The development of female smoking rates in the various provinces is particularly interesting. With the exception of Vienna, the proportion of female smokers has been continuously rising since 1979, particularly in the Burgenland (+11.7 percentage points) and in Upper Austria (+7.2 percentage points). For the whole of Austria, an increase in female smoking rates by 6.2 percentage points has been recorded since 1979. In Vienna, which has always had the highest proportion of female smokers, the rate increased by 5.7 percentage points between 1979 and 1986; since then, however, it has decreased slightly by 0.3 percentage points.[11]

Figure K-13 Regional differences in the development of smoking rates, 1979–1997, by sex

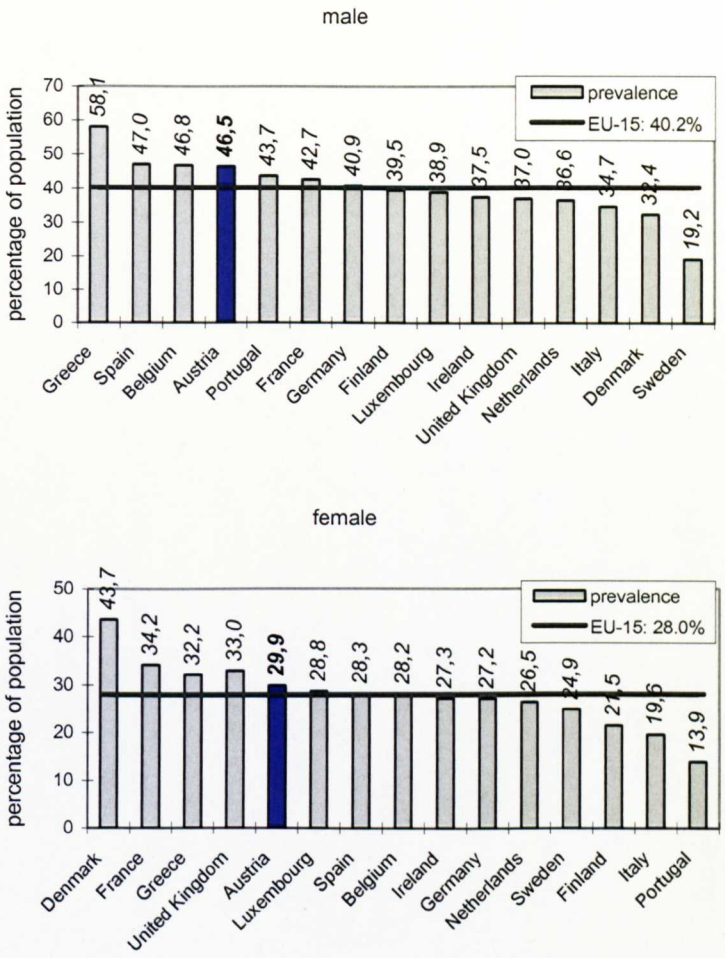


Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Smoking in Austria compared to other EU countries

A fuller understanding of tobacco consumption in Austria can be obtained by means of a comparison with other EU countries. However, due to different sampling methods and questioning, reported national smoking rates not only differ within different surveys of the various countries (as the example of Austria shows) but also between the different surveys conducted by Eurostat (Eurobarometer surveys) or the World Health Organization. According to the data of the latest Eurobarometer survey of the European Commission in 1999[55], both male and female smoking rates in Austria are now well above the European average *(Figure K-14)*. Nearly 47% of men and nearly 30% of women are reported to smoke. According to these figures, Austrian men rank fourth, Austrian women fifth among the 15 EU member states. For men, the highest proportion of smokers is found in Greece, with more than half of the male population smoking, followed by Spain; for women, Denmark is leading, followed by France. The significantly smallest percentages of smokers are those of Swedish men (not included, however, the consumption of *snus*) and Portuguese women.

Figure K-14 European comparison: Percentage of population (15+ years) reporting smoking, by sex, 1999



Source: Eurobarometer 52.1 – European Commission.[55]

Smoking careers

When discussing the development of a smoker's career, Elfriede Urbas differentiated between an initial stage, an experimental stage and a habituation or addictive stage.[11] The initial stage mostly occurs during youth. Role models, social norms and peer group pressure play a significant role in the initiation of a smoking. The probability of taking up smoking at older ages is considered to be very low. The HBSC study by the WHO reports that first smoking attempts are very often undertaken in childhood. According to this study, in most member states, 50 to 80% of children under 15 years of age have already smoked *(see above)*.[12 13]

In Austria, a clear shift in the onset of smoking towards younger ages can be observed, in particular between 1986 and 1997 and especially in women, resulting in an even earlier onset for women than for men. In 1997, more than half of daily smokers had started smoking habitually before the age of 17. Above this age smoking is rarely initiated.

The transition from the initial phase to the experimental phase is largely the consequence of social mechanisms, in particular peer pressure, whereas the transition from the experimental phase to the habituation stage is strongly connected with expectations about the effects of smoking. With increasing age, regular cigarette consumption increases and finally consolidates.[11] Continuous regular smoking is associated with nicotine addiction. However, nicotine addiction can occur even after just starting smoking. Besides the highly addictive character of nicotine, this process is enforced by the particular additives in cigarettes, which promote nicotine addiction.[96 203 204] Most smokers then smoke until middle age, even though they are conscious of the health risks. The results of this latest Austrian smoking survey lead to the conclusion that more than one third of female ex-smokers and more than half of male ex-smokers have a smoking career of at least 20 years or more.[11] This, together with the now extensive evidence of the addictive nature of nicotine, makes the tobacco industry's term for smokers as people "who choose to smoke" ring rather hollow.

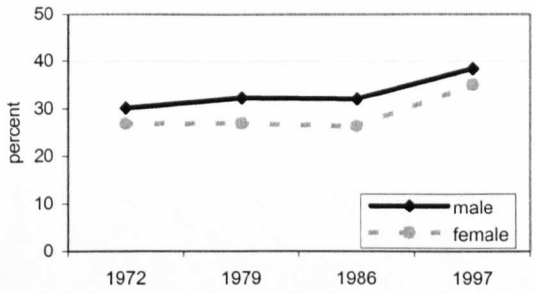
Apart from age, the most important determinants of starting smoking and of the course of the smoking career seem to be gender, birth cohort, educational level, employment status and region of residence. Persons with less education, those who will go on to be blue-collar workers, and the unemployed not only tend to start smoking at an earlier age, but are less likely to give up smoking than are higher educated persons, those in employment and civil servants. The main reasons for the relatively high probability of younger women giving up smoking seem to be related to pregnancy and childbirth *(Chapter 7)*.[11]

Attitudes towards smoking / Smoking cessation

Although smokers are very often fully aware of the health risks of smoking, they still take the risk. A process of cognitive dissonance, i.e. cognitive strategies playing down a risk by underrating the damaging and harmful consequences, underestimating the personal risk and/or emphasizing the possibility of stopping harmful behaviour any time, play an important role. Furthermore, although there is some consideration of risks and benefits, the habituation of smoking leads many smokers to continue their health damaging behaviour. Prochaska and colleagues describe in their transtheoretical model the following stages of change: pre-contemplation, contemplation, preparation, action, and maintenance.[466 467]

Since 1986, however, preparedness in Austria to stop smoking has been increasingly marked in both men and women *(Figure K-15)*. According to a recent survey by the Nicotine Institute in Vienna, more than half (55%) of all smokers are not happy with their smoking habits (dissonant smokers) and would like to reduce or quit smoking in the near future. The percentage of those who want at least to reduce smoking (37%) is about double of those who would like to give up smoking completely (18%).[53]

Figure K-15 Quit rate of smokers in Austria, 1972 to 1997 (in percent)

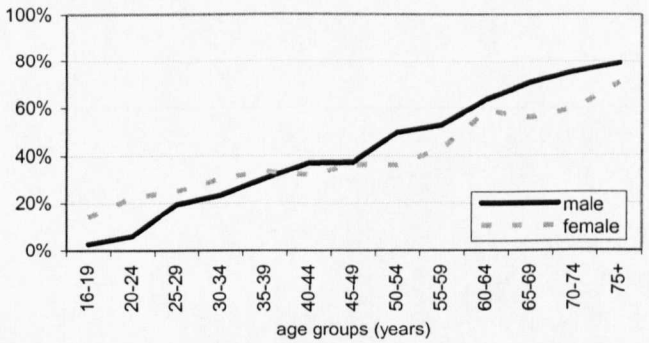


Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

In 1997, 1.1 million ex-smokers were living in Austria; this represents more than one third (37.1%) of all current or past smokers. However, a more meaningful source of information on the preparedness to give up smoking than the proportion of ex-smokers within a population is the quit rate, indicating the proportion of ex-smokers related to all smokers and ex-smokers. Although the proportion of female ex-smokers is much lower than that of males (because of fewer female smokers), the quit rate is similar in both sexes (men 38.4%, women 35.1%).

Being aware of the health risks, many smokers try more or less successfully to give up smoking. There are, however, certain groups that are more successful than others *(Figure K-16)*. For example, the tendency to stop smoking increases with age. Interestingly, among the younger population, the quit rate of women is markedly higher than that of men which, as noted above, is likely to reflect events around pregnancy and childbirth. In contrast, the gender ratio is reversed among the elderly.[11]

Figure K-16 Quit rate of smokers in Austria, by age and sex (in percent)



Source: Microcensus on smoking behaviour 1997 (Statistics Austria).[11]

Another important determinant of the course of a smoker's career is level of education. Preparedness to give up smoking is highest in the group with the highest level of education (university graduates). Roughly half of male smokers in this group (47.9%) and more than 40% of female smokers (42.7%) have given up smoking. In addition, higher educated individuals are more inclined to give up smoking at an earlier age.

An analysis of heavy smoking revealed that male heavy smokers (one to two packets of cigarettes per day) and very heavy smokers (more than two packets per day) show the highest quit

rates, while male smokers consuming up to 20 cigarettes per day have the lowest quit rate. Among female smokers, it is also the very heavy smokers (41 cigarettes and more) who are most prepared to give up smoking, but also those who only smoke up to 10 cigarettes per day.[11]

According to the 1997 microcensus, which included a question on the main motive for smoking cessation, giving the choice between several answers (financial reasons, health reasons, anti-smoking campaigns or other reports on harmfulness of smoking, information/advice by doctor, personal advice of relatives or friends, pregnancy, other reasons), the main motive is concern about health consequences (43.9% for men, 36.1% for women). For women, pregnancy also plays a significant role (17.9%). As reported by interviewees, the effects of personal advice by relatives and friends, doctor's advice, reports on the harmfulness of smoking, and anti-smoking campaigns[b] are very limited. With increasing education, the reported concern for health gains importance. Financial constraints are mainly a motivation for stopping among very young people and persons with a low level of education.[11] This is consistent with the findings that price elasticity is greatest among the poor and the young people, especially children[3 130 198 468] *(APPENDIX F)*.

The 1997 smoking survey (microcensus 1997) also identifies behaviours viewed as "alternatives" to smoking cessation. For many people a reduction of tobacco consumption, a change of brand and switching to lighter cigarettes is regarded as a means of gaining health benefits while avoiding quitting. Roughly one in four (22.5%) of daily smokers in Austria have changed their cigarette brand over the last five years – women more frequently than men and individuals in urban areas more frequently than others.[11] Again, these results confirm studies on what smokers believe about light and ultralight cigarettes[469] and the successful marketing strategies of the tobacco companies in promoting "light" cigarettes as a "healthier" option, particularly targeting women *(Chapter 3)*.

Compared to previous decades, smoking careers have thus changed, with an earlier age of taking up smoking, especially for women, and an increase in quit rates. The evidence that these have been affected by the various measures to support those who are willing to give up smoking will be discussed in a later chapter on anti-smoking measures in Austria *(Chapter 8)*.

According to the recent Vienna Study on Addictive Drugs[51], there is a tendency towards convergence of smoking behaviours by men and women. While more men than women still smoke regularly, the differences are progressively shrinking. However, gender differences in different age-groups remain large. While young men (under 30 years of age) are most likely to smoke (according to this study 46%), decreasing constantly with age to 32% among the over 50 year olds, the female smoking rate of roughly 30% remains the same throughout these age groups, from the under 30 year olds to the over 50 year olds. Only beyond the age of 60 is there a marked decrease in the proportion of smokers.

A small study by the Nicotine Institute and the Institute of Social Medicine reports that 55% of the almost 5,000 respondents are not happy with their smoking (dissonant smokers). The proportion of those who want to quit versus those who want to reduce cigarette consumption is 2:1.[53 470 c]

[b] The latter two as good as non-existent in Austria.

[c] This result has been used by Groman and Kunze as an argument to address in particular the group of "reducers" in their concept of smoking cessation. Campaigns should be developed which are also attractive to those who want to reduce instead of quit smoking.[470]

Passive smoking

Despite legal requirements for protection of non-smokers at their workplace (excluding workplaces in the catering business and other workplaces where smoking is allowed for customers), as laid down in article 30 of the Employees' Protection Law of 1994 (amended in 1999 and 2001; *Chapter 8; APPENDIX M*), one in three employees (smokers as well as non-smokers and ex-smokers) reported in the 1997 microcensus survey that they were exposed to second-hand smoke at their work place, men (31%) more frequently than women (26%). More than one third of those affected (38%) felt harassed by the smoking of their colleagues, women more often (43%) than men (35%) and non-smokers (female 44%; male 37%) more often than ex-smokers (female 38%; male 32%).[11]

In addition, the microcensus data indicate that nothing changed with regard to "passive smoking at the work place" between 1986 and 1997. However, a slight change in attitude regarding the harassing effects of passive smoking can be observed; it is increasingly recognised as an issue, and women still react more sensitively to it than men. However, this is not to the same extent as in other European countries, where smoking in the presence of non-smokers, particularly pregnant women and children, is seen as highly anti-social or even irresponsible behaviour.

APPENDIX L

Overall health levels

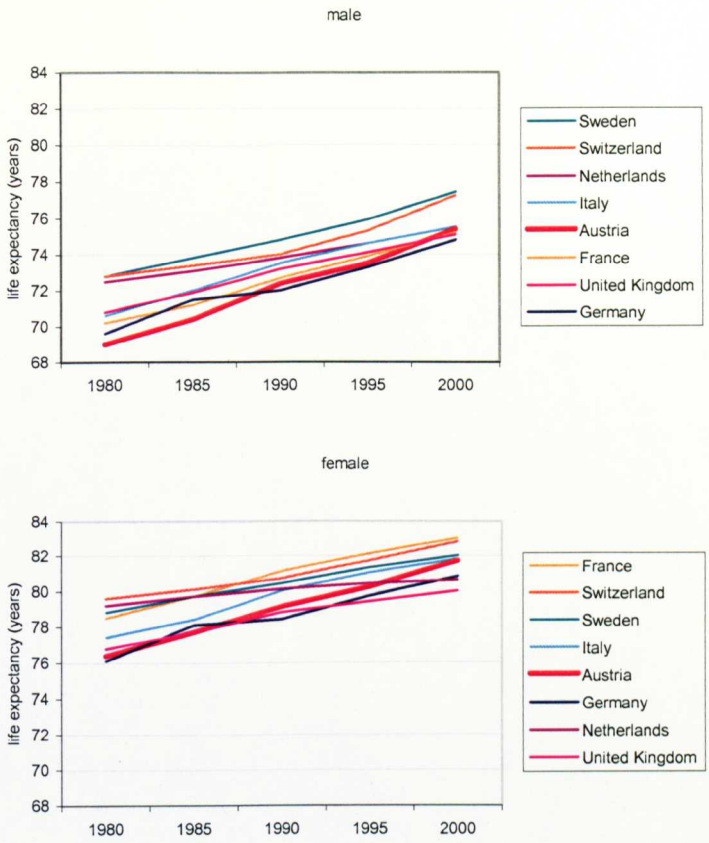
Life expectancy

As in other western and central European countries, life expectancy in Austria has increased markedly, especially during the last two decades – although the gains in Austria have been particularly impressive compared to most other European countries. In 2003, life expectancy at birth was 81.8 years for women and 76.0 years for men.

Compared with its seven neighbouring countries, the Czech Republic, Slovakia, Hungary, Slovenia, Italy, Switzerland and Germany, Austria is clearly in the upper half, comparable to Germany, Italy and Switzerland – the latter having by far the highest life expectancy, while Hungary has the lowest by far. This reflects the now well-recognised west-east gap, with much lower life expectancy in the former communist countries of central Europe, although a west-east gap is also visible within Austria.[471]

When compared with other major western European countries, Austria had a below-average life expectancy in the 1980s. Since then, the country has definitely caught up; in 1990, it even overtook Germany (whose rates were somewhat brought down by the addition of the new Länder after unification) and is now slightly above the European average for both women and men. Although the changes in Austria are inadequately studied, it is likely to reflect a combination of improved living conditions, including diminished social differences and rapid increase of income (particularly since the 1970s), better medical care, and decreased infant mortality, just as in other comparable countries. In this respect, a certain "catching-up process" on the part of Austria is definitely noticeable.[472]

Figure L-1 Life expectancy at birth, 1980–2000*)



* Latest available data Italy 1998, Germany and United Kingdom 1999.

Source: OECD Health Data 2002 and various national institutes of statistics.

Taking 1951 as a baseline, the increase in life expectancy is 20.6% for women and 21.7% for men. However, on reaching the age of 60, women can expect to live another 24.3 years on average; men, another 20.4 years (further life expectancy). This represents an increase in further life expectancy of nearly 41% (or 7 years) for females and 37% (or 5.5 years) for males since 1951. Thus the increase in additional life years has been more marked for men than women, in particular during the 1990s *(Table L-1)*.[243]

Table L-1 Development of life expectancy in Austria, 1951-2001

Year	life expectancy at birth		further life expectancy at age 60	
	male	female	male	female
1951	62.38	67.75	14.89	17.25
1961	66.47	72.84	15.53	18.99
1971	66.64	73.67	15.20	18.99
1981	69.28	76.41	16.36	20.40
1991	72.41	79.05	18.03	22.21
2001	75.91	81.68	20.42	24.25

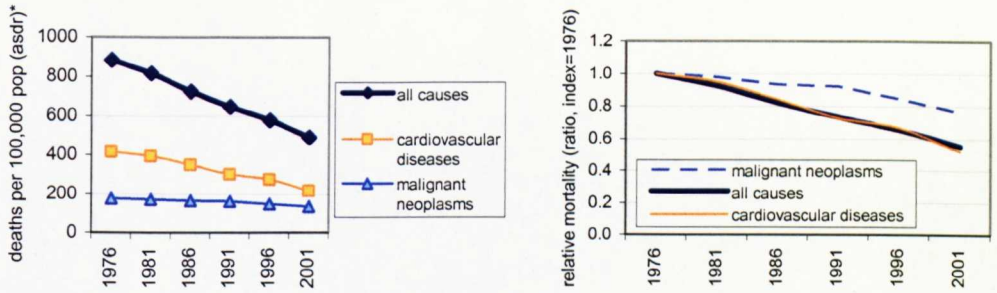
Source: Statistics Austria.[243]

Mortality and causes of death

In Austria, until the end of 2001, causes of death were encoded according to the ninth revision of the International Classification of Diseases (ICD-9). Since January 2002 coding has been based on the tenth revision (ICD-10). To enable bridging, both coding systems, ICD-9 and ICD-10, were used in parallel until the end of June 2002. Similarly, cancer incidence (encoding of localisation of histology) has been based on ICD-O (Oncology)-2 since January 2002 *(see further down section on cancer incidence)*. As only few data were available in ICD-10 or ICD-O-2 at the time of analysis, the data in this report are still encoded according to ICD-9.

All-cause mortality in Austria has fallen markedly over the last three decades. In 1974, the age-standardised mortality rate for the Austrian population was 897.8 per 100,000, while in 2001 the rate was only 490.1 per 100,000, representing a decrease of 45% *(Figure L-2)*.[243] The observed decline is mainly attributable to the decrease in mortality from heart diseases and malignant neoplasms. A gender-specific analysis confirms that the decline in relative mortality is similar in both sexes.

Figure L-2 Development of mortality rates and relative mortality – all causes, CVD and cancer, Austria 1976–2001



* European standard population, age-standardised (World Health Statistics Annual 2001, online version).[43]

Source: Statistics Austria[243]*; own computations.*

Compared with comparable countries in western Europe, mortality in Austria – as in Germany and the United Kingdom – was among the highest until the mid-1980s, despite the decrease from 1970 onwards. However, a focus on the last decade makes the marked decrease in mortality for Austrian men and women since 1990 even more visible.[471]

Like in most other western European countries, heart disease and cancer are still the predominant causes of death in Austria. In 2001, more than half (51.3%) of deaths were caused by cardiovascular diseases and one in four deaths (24.7%) were due to cancer. For women, the third most frequent cause of death are diseases of the digestive tract as well as diseases of the respiratory organs (in particular a marked increase in lung cancer can be observed within the female population). For men (and the population in general), the third most frequent cause of death are accidents, poisoning and acts of violence (injuries).

Table L-2 Age-standardised mortality rates by causes of disease, Austria 2001

Causes of death <ICD-9>	mortality rate *		
	male	female	total
cardiovascular diseases <390-459>	262.1	172.8	217.5
malignant neoplasms (cancer) <140-208>	166.3	103.3	134.8
injuries and poisoning <E800-E999>	61.2	20.5	40.9
diseases of the digestive tract <520-579>	33.4	16.6	25.0
diseases of the respiratory tract <460-519>	33.1	16.0	24.6
other diseases <001-139, 210-389, 580-799>	56.8	38.0	47.4
All causes	**613.0**	**367.2**	**490.1**

* Deaths per 100,000; age-standardisation based on European standard population (World Health Statistics Annual 2001, online version).[43]

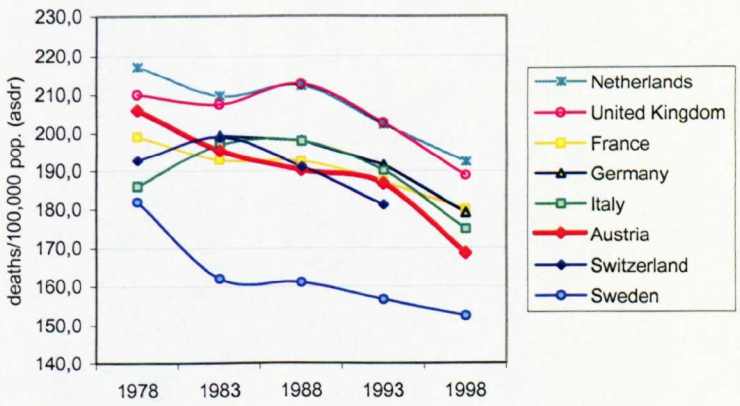
Source: Statistics Austria.[243]

Cancer mortality

Within cancer mortality, cancer of the digestive tract is the leading cause of death for both men (age standardised mortality rate/100,000 [ASDR] 57.0) and women (ASDR 33.2). The second most frequent cause for women is breast cancer (ASDR 19.9), for men cancer of the respiratory system (ASDR 43.6), in particular lung cancer.[41]

Compared with its neighbours, Germany, Italy and Switzerland, Austria has experienced a marked decline in cancer mortality over the last two decades. The standardised mortality rate is now low and since the early 1980s ranking below Germany. Italy and Switzerland show equally low rates, although without the previous marked decrease. The United Kingdom, in comparison, ranks in the upper range, although showing a marked decrease since the end of the 1980s, while Sweden has clearly and continuously for the last two decades had the lowest cancer rates of all *(Figure L-3)*.[41]

Figure L-3 Trends in cancer mortality in selected European countries, 1978–1998



Source: OECD Health Data 2002.

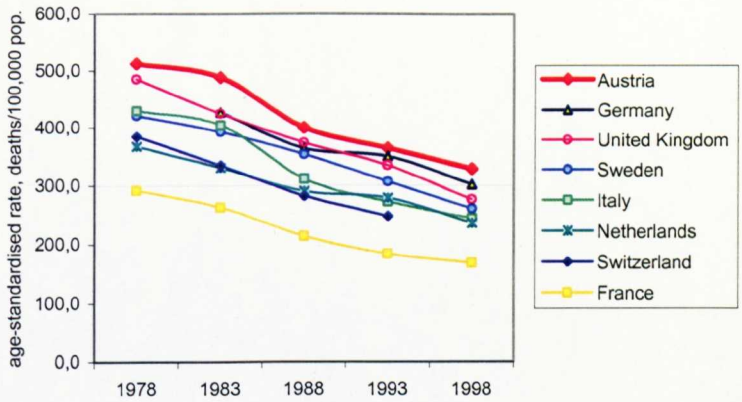
Lung cancer, although not the only type of cancer attributable to smoking, has been known for a long time to be caused predominantly by smoking. However, while male lung cancer mortality in Austria has been decreasing since the 1960s, this figure is sharply rising for women reflecting the growing number of female smokers. By 2003, malignant neoplasms of the respiratory

organs had attained fourth place amongst the cancer-related deaths of Austrian women (ASDR 12.8), closely following cancer of female reproductive organs (ASDR 13.6).[243]

Cardiovascular mortality

Comparing mortality from cardiovascular diseases in several European countries, Austria – despite its continued decrease over the last two decades – still ranks in the upper part of the range, above its neighbours Germany, Italy and Switzerland. The United Kingdom, in comparison, ranks a bit lower, between Germany and Sweden *(Figure L-4)*.[41]

Figure L-4 Trends in mortality of diseases of the circulatory system in selected European countries, 1978–1998



Source: OECD Health Data 2002.

Cancer incidence

The onset of cancer is a multi-factorial event where genes, lifestyle and environmental factors interact. Certain risk factors play a decisive role (e.g. tobacco consumption and lung cancer, or sunburn and skin cancer).

In 1969, the Austrian Cancer Register was instituted formally. Since 1983, data quality has been considered to be excellent, although data from earlier years are more problematic. Until the end of 2001, coding was based on ICD-9 (for localisation) and ICD-O-1 (encoding of histology). Since January 2002 (double-coding until end of June 2002), and exclusively since summer 2002, the more detailed ICD-O (Oncology)-2 has been used for both localisation and histology. The transformation of the entire cancer data base from ICD-9 and ICD-O-1 to ICD-O-2 was performed with a programme developed by IARC (International Agency for Research on Cancer). Likewise, an IARC programme enables the conversion of ICD-O-2 to ICD-10 to compare cancer data with mortality data or other morbidity data.

In 1999, the last available year for which comprehensive data exist at the time of analysis (2003), approximately 32,500 Austrians were diagnosed with cancer, not including the 1,500 cases of carcinoma in situ and the 2,350 cases of malignant neoplasms of the skin. The age-standardised incidence rate was 286.0 per 100,000 for women and 397.1 per 100,000 for men[473], indicating a risk of being diagnosed with cancer that is nearly 39% higher for men than

for women. In general, however, the age-standardised rates for both sexes exhibit a decreasing curve.

Cancer sites

As in previous years, the most frequent types of cancer in the Austrian population – in absolute numbers – concerned breast cancer (27.3% of all female cancers) among women, followed by colorectal cancer (14.3%); for men carcinoma of the prostate (23.8% of all male cancers), followed by lung cancer (15.5%) and colorectal cancer (14.4%). However, if malignant neoplasms of the female genital organs (uterus, cervix, ovaries, etc.) are considered as a group, this represents the second most frequent type of cancer in women (14.9% of all female cancers). Similarly, aggregation of all neoplasms affecting the urinary organs (bladder and kidneys) in men – rates that are very high in the male population and can at least partly be attributed to smoking behaviour – reveals the large contribution of cancers at this site to overall cancer incidence in Austrian men (11.2% of all male cancers).[243]

Overall (i.e. without considering sex and the two gender-specific localisations of prostate and mammary gland), colorectal carcinoma and malignant neoplasms of the respiratory organs (mainly lungs) constitute the most frequent types of cancer amongst the Austrian population. Both types of cancer are known to be closely related to lifestyles. Diseases of the lower respiratory tract in particular are predominantly linked to tobacco consumption (examined in more detail in following sections on smoking-related diseases) while intestinal cancer is also related to diet, albeit modified by genetic susceptibility.

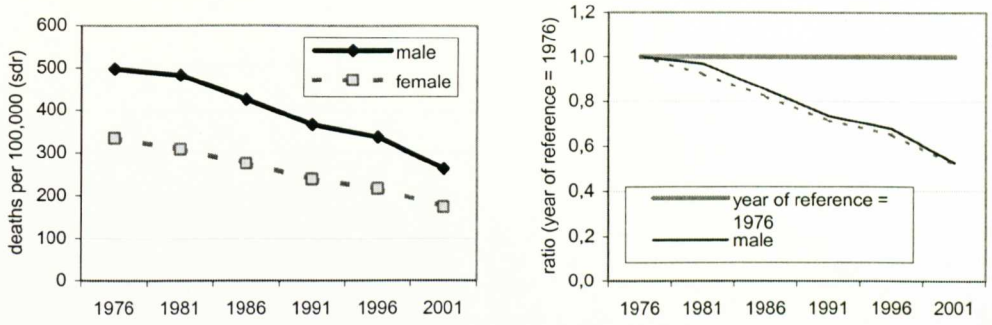
Smoking-related disease and mortality in Austria

Mortality of cardiovascular diseases

The development of a cardiovascular disease, especially ischaemic heart disease, is one of the major health consequences of tobacco consumption. In 1964, the Advisory Committee to the Surgeon General calculated a mortality ratio of cigarette smokers compared to non-smokers of 1.7 with regard to coronary heart disease.[474] The excess mortality of smokers from vascular disease is particularly noteworthy because absolute death rates are much higher than those due to specific cancers or other causes associated with smoking. Therefore, in absolute numbers, cardiovascular diseases (especially ischaemic heart disease and stroke) account for more smoking-attributable deaths at a population level than other causes which might have a higher relative risk (as, for instance, lung cancer). Particularly at younger ages (<50 years), smokers have a five to six times higher mortality rate than non-smokers, suggesting a chance of 70 to 80% that death among smokers in younger ages is caused by their previous smoking, and that vascular disease caused by smoking accounts for a threefold excess mortality rate in middle age.[4]

From mortality statistics it can be seen that cardiovascular diseases (ICD-9 390-459) contribute the greatest share of Austrian mortality. In 2001, the standardised mortality rate for men was 262.1 per 100,000, for women 172.8 per 100,000. Among cardiovascular diseases, the largest share is accounted for by ischaemic heart diseases. Over the last 25 years, a significant decrease in cardiovascular diseases can be observed, especially in men (Figure L-5).[243]

Figure L-5 Cardiovascular diseases. Age-standardised mortality rates and development of relative mortality by sex, Austria 1976–2001*

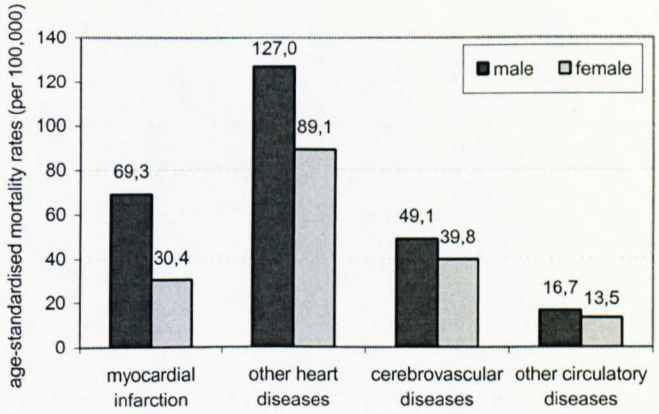


* Age-standardisation based on European standard population (World Health Statistics Annual 2001, online version).

Source: Statistics Austria – mortality statistics; own computations.

The lower rate of cardiovascular deaths among women *(Figure L-6)* is well-recognised and reflects a variety of factors, both physiological (the protective effect of oestrogen until the menopause) and lifestyle (smoking).

Figure L-6 Cardiovascular diseases. Age-standardised mortality rates by sex, Austria 2001



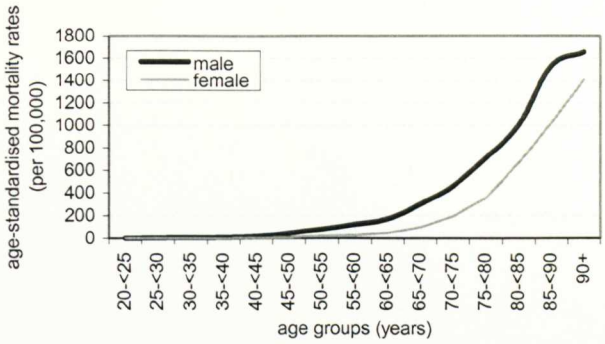
Source: Statistics Austria – mortality statistics.[243]

Although cardiovascular mortality declined significantly over the last 25 years, mortality rates in Austria are relatively high for both men and women compared to other western European countries.

Ischaemic heart disease

As expected, men exhibit higher mortality rates for cardiovascular diseases – particularly for myocardial infarction – than women in all age groups, except the over 90 year olds.

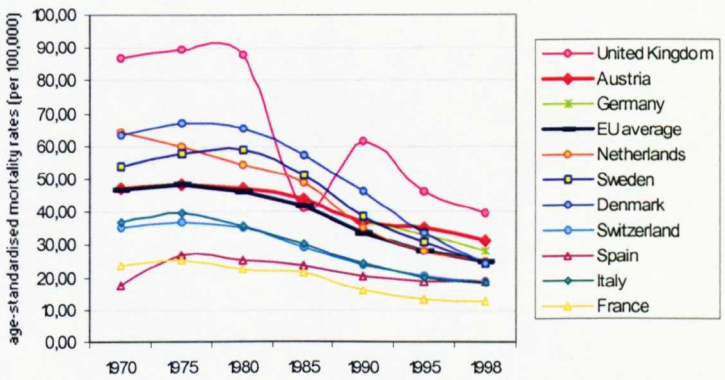
Figure L-7 Myocardial infarction. Age distribution of mortality rates by sex, Austria 2001



Source: Statistics Austria – mortality statistics.[243]

All western European countries have experienced a decline in deaths from ischaemic heart disease over recent decades but, as Figure L-8 shows, the rate of decline in Austria has been slower than elsewhere.[250]

Figure L-8 Ischaemic heart disease in selected European countries* and EU average, ages 0–64 years, standardised mortality rates, 1970–1998**



* Including the western neighbour country Switzerland.

** Unequal intervals, as due to incomplete availability of data, 1998 was selected as year of reference (Switzerland: 1997).

Source: WHO – Health for All database, last updated January 2002.[250]

Smoking-related cancer (incidence and mortality) in Austria

About one third of all cancers can be attributed to smoking. Besides the lungs, the organs most affected by smoking are oral cavity, lips, pharynx, larynx, trachea, oesophagus, bladder, kidneys, pancreas and stomach.[2 199 205 209-212] Although all of these cancers have causes other than just smoking, cancer of the respiratory system including oral cavity (ICD-9 140-149, 160-165), oesophagus (ICD-9 150), stomach (ICD-9 151), pancreas (ICD-9 157) and urinary tract (ICD-9 188, 189) accounted for 51% (male) and 32% (female) of all cancers in Austria in 2001.[243]

However, lung cancer accounts for the greatest share of cancer directly related to smoking, although the proportion of male deaths resulting from cancer of the lips, oral cavity and throat

(e.g. cancer of the tongue, etc.) should not be underestimated. In Austria, more than 3,000 people die of lung cancer every year, i.e. one in six (17%) of all cancer deaths is due to lung cancer. In 2001, this figure represented 17.3% of all cancer deaths or 4.3% of all deaths, respectively.

Lung cancer (including bronchi and trachea)

Malignant neoplasms of the trachea, bronchi and lungs (ICD-9 162) are the most common cancers attributable to smoking. According to WHO- and other estimates[2 8 209], approximately 90% of all lung diseases are tobacco-induced. However, while this type of cancer is not *only* caused by smoking, male and female smokers are ten to twenty times as likely as non-smokers to contract the disease.[2 8] However, when interpreting the decline in male lung cancer mortality in recent years the contribution of other carcinogens, such as cadmium exposure among some industrial workers, should also be noted, although any effect will be minor compared with the impact of changes in tobacco use. The actual development of the disease is preceded by many years of tobacco consumption. Thus the peak frequency is only reached at about 50 to 60 years of age.

Incidence and mortality

As the issue of lung cancer is discussed in great detail in the thesis *(Chapter 7; 7.2.3)*, this short overview is just included for completeness.

Over the last two decades, after a peak in incidence among men in 1993, a marked downward trend in lung cancer has been observed for men. Between 1993 and 1999, the latest year for which data were available, incidence fell by more than 20%. In women, on the contrary, there has been an increase in incidence of more than 17% between 1990 and 1999. This is consistent with the rising rate of female smoking since the early 1970s, a phenomenon that can be expected to lead to further increases over future decades.

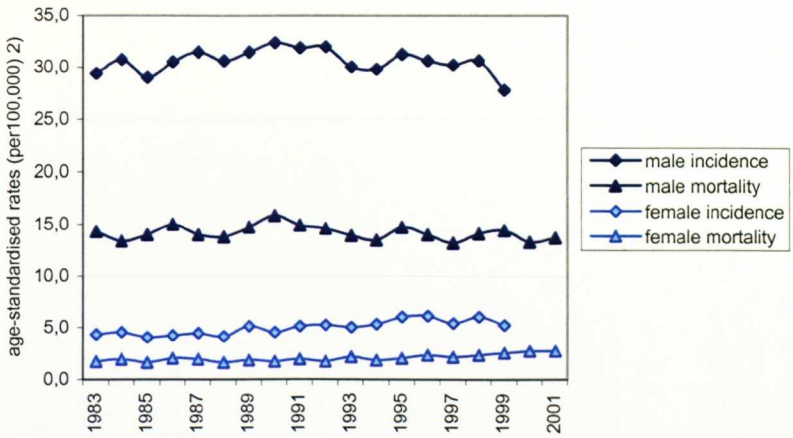
In 1999, 3,602 persons – 70% of them men – developed lung cancer. This corresponds to an age-standardised incidence rate of 61.6 per 100,000 for men compared to 19.0 per 100,000 for women.[243]

Male mortality from lung cancer fell significantly over the last two decades; between 1983 and 2001 it dropped by –28%. Over the last decade, however, the decrease was especially marked (–22.5% between 1991 and 2001). In women, consistent with the increase in lung cancer incidence, lung cancer mortality is on the rise, increasing by 35% between 1983 and 1999.

Cancer of the upper respiratory tract (oral cavity, lips, pharynx, larynx) and oesophagus

Cancer of the upper respiratory tract, including oral cavity, lips, pharynx (ICD-9 140-149) and larynx (ICD-9 161) and cancer of the oesophagus (ICD-9 150) are also known to be related to smoking.[2 209] For Austria, the data show that these cancers are mainly found in the male population, although the male incidence rates seem to be on the decrease.[243] The male mortality rates still show only a very slight decrease. However, corresponding with the data on lung cancer, female incidence as well as mortality rates are on the rise *(Figure L-9)*.

Figure L-9 Cancer of the upper respiratory tract and oesophagus. Age-standardised incidence- and mortality rates by sex, Austria 1983–2001*



* Cancer incidence: latest available year under review 1999.

** Age-standardisation based on European standard population (World Health Statistics Annual 2001, online version).[43]

Source: Statistics Austria – cancer registry and mortality statistics.[243]

Other smoking-related diseases

Other smoking-related diseases include asthma, bronchitis, respiratory infections, and chronic obstructive pulmonary disease (COPD).[2 130 206 209 212] In most industrialised countries COPD is one of the three major killers in adult life.[6] In Austria, about 400,000 persons are estimated to suffer from COPD, representing 5% of the whole population or more than 10% of over 40 year olds, although this is likely to be an underestimate. 90% of sufferers are reported to be smokers, most aged 40 years and over.[251]

There is a lack of representative statistics on the incidence of other smoking-related diseases, in particular with relation to the individual's smoking behaviour, so no data for Austria can be given here. The 1999 microcensus on health asks about difficulties in breathing and 3.8 in 1,000 men and 4.0 in 1,000 women stated they suffered from one of these ailments.[254]

International comparisons of overall mortality data from bronchitis, emphysema, and asthma are problematic, in particular because of different national coding traditions for deaths at old age where multiple processes are present.

Environmental tobacco smoke and diseases related to passive smoking

Passive smoking, or exposure to second-hand smoke, is the involuntary inhalation of burnt tobacco substances and additives from the surrounding environment. The term environmental tobacco smoke (ETS) describes a combination of exhaled smoke from active smokers (mainstream smoke) and the smoke coming from smouldering tobacco between puffs (sidestream smoke). Research on the health effects of passive smoking must be interpreted with care; the international tobacco companies have long engaged in a major endeavour to distort the evidence, including selective publication and outright fraud.[475 476]

Sidestream smoke is especially health endangering. The lower combustion temperatures create higher levels of carcinogenic and otherwise harmful substances than in mainstream smoke, i.e. the smoke inhaled by the smoker in the process of smoking.[6 477] These include carbon monoxide, formaldehyde, ammonia, cadmium, arsenic, lead, acetone, phenol, benzene, cyanide, pyridine, nickel, turpentine, butane, propylene glycol, and nicotine. ETS is an important source of exposure to toxic air contaminants indoors, but there is also some exposure outdoors, in the vicinity of smokers.[255] The concentration of health endangering and carcinogenic substances in closed rooms can lie markedly above values found in ambient air in most polluted urban areas.[172 478-481] In addition, the characteristics of ETS change as it ages and combines with other constituents in the ambient air.[255] ETS meets the criteria of the American Occupational Safety and Health Administration for classification as a potential occupational carcinogen.[482] In 2000, Finland was the first country to include ETS in national legislation as a carcinogen[139] *(APPENDIX G)*.

To non-smokers, tobacco smoke has always been unpleasant, causing irritations of throat, nose and eyes, coughing, head-ache, dizziness, and general nuisance caused by the smell. However, it is only in the past 20 years or so that there has been research showing that passive smoking is not only a nuisance but also harmful to health. In an increasing number of countries, therefore, efforts have been made to protect non-smokers from the hazards of other people's smoking and more and more environments are being made smoke-free. In Austria, public awareness of the health endangering effects of ETS is still very low and legislation is weak.

Even though it has been contested extensively in the past, it is now beyond dispute that ETS may cause disease in exposed persons who do not consume tobacco products themselves (passive smokers).[2 213 214 483] In particular, the comprehensive reviews published as Reports of the Surgeon General,[206 208] the reports and documents of the U.S. and California Environmental Protection Agency,[212 255 484-487] and the publications of the National Research Council[488] and the American National Cancer Institute[489], but also in more recent reviews like, for example, the International Agency for Research on Cancer[199], have causally associated ETS exposure with a variety of adverse health outcomes, acting through developmental, respiratory, carcinogenic and cardiovascular effects, increasing the risk of outcomes as diverse as sudden infant death syndrome, cardiovascular mortality, and childhood asthma.[255 490] Over the last 20 years epidemiological evidence has accumulated that ETS is in particular a cause of cardiovascular disease, lung cancer and respiratory illnesses such as asthma and bronchitis. ETS is also associated with certain cancers, perinatal and postnatal manifestations of developmental toxicity, sudden infant death syndrome (SIDS) and low birth weight infants, and adverse impacts on male and female reproduction. In addition, there is suggestive evidence of an association between ETS and spontaneous abortion, cervical cancer, and exacerbation of asthma in adults. [212 255 485 486]

While some effects are immediate responses to ETS,[491] chronic health consequences very often emerge after a long time-lag. Among the best established health consequences of second-hand smoke are lung cancer, lung diseases, lung function impairment, chronic obstructive pulmonary disease (COPD), nasal-sinus cancer, asthma and other respiratory diseases (e.g. lower respiratory infections), cardiovascular diseases (particularly ischaemic heart diseases) and other chronic and life-threatening diseases. It also aggravates existing diseases, as for instance asthma.[2 206 209 210 212 262 478 480 481 484-487 492-494]

ETS is harmful to all who are exposed to it, but especially harmful to children and to people with respiratory and heart problems. It poses a particular risk to hospitality industry employees who spend many hours every day in a smoke-filled environment *(see later)*.

The possibility of tobacco smoke having health effects not only on smokers but also on non-smokers was considered in Germany as early as 1928, as an explanation for the lung cancers observed in non-smoking women. In 1971, a British study found an increased risk of bronchitis and pneumonia in children in their first year of life if the parents smoked.[495] Subsequent studies in Britain and the United States confirmed not only these findings on infants but extended them to all pre-school children and adding further possible health effects.[209 212] Together, these findings show that children, especially up to the age of five years, experience an increase in acute and chronic illnesses of the respiratory tract when exposed to tobacco smoke in their family. In particular, they suffer more frequently from infections and other diseases of the respiratory tract, middle-ear infections, have significantly worse lung functions and suffer more frequently from chronic lung diseases, bronchitis, asthma and even cancer. ETS increases the risk of acute respiratory illness in children by 50-100%.[264] In children already suffering from asthma passive smoking causes more frequent and more acute fits of asthma, leading to a faster progression of the damage of lungs. In very small children ETS doubles the risk of sudden infant death syndrome.[2 6 206 209 212 255 264 478 490 496 497] There is some evidence suggesting that parental smoking adversely affects also child development and behaviour.[498]

In its report on respiratory health effects of passive smoking of 1992, the U.S. Environmental Protection Agency (EPA) identified a series of major respiratory health effects of ETS exposure by children *(Box L-1)*:[484]

Box L-1 Major respiratory health effects by ETS exposure on children

ETS exposure of children

- increases the risk of lower respiratory tract infections such as bronchitis and pneumonia
- increases the prevalence of fluid in the middle ear, a sign of chronic middle ear disease
- irritates the upper respiratory tract and is associated with a reduction in lung function
- increases the frequency of episodes and severity of symptoms in asthmatic children
- is a risk factor for new cases of asthma in children.

A study of 401 elementary schoolchildren (aged 6-10 years) in Vienna identified not only physical effects on children but also mental ones. In particular, girls showed a significantly higher level of hyperactivity when their mother smoked.[499]

Maternal smoking during pregnancy means passive smoke exposure for the foetus (sometimes referred to as tertiary smoke) and adversely affects foetal development. Infant mortality is also

higher and birth weight is reduced by approximately 200g on average (degree of reduction is dose-related) when mothers smoke.[2 206 263]

The effects on adults have been more difficult to assess, perhaps because long exposure is required to produce substantial increases in risk.[209] It is also difficult to measure exposure to ETS accurately and indicators range from surrogate or indirect indicators (e.g. self-reported exposure and description of ETS source, usually obtained by questionnaires) to direct measurements of exposure and of biomarkers (nicotine and its metabolic cotinine in serum and urine, or white cell adducts).[4 489] In addition, the amount of ETS exposure of a non-smoker is influenced by the number of smokers in the room, the intensity of their smoking, the duration of exposure, the volume of the indoor environment, the ventilation characteristics, and the breathing pattern, as well as the activity of the non-smoker.[483] At the same time, homes, workplaces and public places are all sources of ETS exposure and have to be considered, as well as the person's own smoking behaviour (e.g. ex-smoker, occasional smoker). In addition, typically only some of the surveyed subjects report that they are or were actually exposed to ETS. Another factor to consider is that, due to the widespread nature of ETS, the number of totally unexposed persons is rare.[171]

Consequently, studies of health effects of passive smoking only took place relatively late, starting in 1981 with two studies reporting of an increased risk of lung cancer in non-smokers if their spouses smoked.[258 259] In addition, an increased risk of chronic respiratory disease and myocardial infarction was reported at that time. Since then, several studies have been undertaken to measure the consequences of exposure to ETS. In summary, there is now evidence from several high quality studies from the United Kingdom, the United States, Japan, and New Zealand that individuals that have been exposed to ETS not only have a higher risk of developing one or more of the mentioned diseases, but also die younger than those who are not. These include the US National Research Council and the US Surgeon General reports in 1986, the National Health and Medical Research Council of Australia report in 1987 and the UK Independent Scientific Committee on Smoking and Health report in 1988.[500] In 1992, the US Environmental Protection Agency published a review that classified ETS as a human Class A carcinogen.[212] Subsequently, the WHO, the UK Scientific Committee on Tobacco and Health[213], and the International Agency for Research on Cancer[199] have published systematic reviews and meta-analyses that confirm the adverse effects of ETS.[500]

In particular, lung cancer has long been associated with exposure to ETS. Since the late 1980s, more than 42 case-control and 6 longitudinal studies have been reported on this relationship.[4 130 262 480 481 494] According to a more recent study of the university hospital Essen/Germany in cooperation with the IARC and the WHO, about one in four cases of death due to lung cancer is attributed to passive smoking.[501] A most recent review by 29 scientists convened by the IARC concluded that even an average degree of passive exposure to tobacco products can cause lung cancer in people who have never smoked.[199] A review by Law and Hackshaw and a meta-analysis of 37 published studies by Hackshaw and colleagues found strong and consistent evidence that passive smoking increases the risk of lung cancer by 24% [95% CI: 11-38%], compared to unexposed non-smokers.[264 492] Other experts groups have also found ETS to be a cause of lung cancer in non-smokers.[212 213 255] Thus, there is now clear scientific consensus that passive smoking is definitely a cause for the development of lung cancer.[199 264]

In addition, passive smoking is also associated with an increase in risk of chronic respiratory disease in adults of 25% [95% CI: 10-43%].[264] It may also lead to a deterioration of the state of health of chronically ill persons. It may cause or aggravate diseases of the respiratory tract and may deteriorate the disease pattern of angina pectoris. Depending on duration and intensity of exposure (dose-response effect), the risk of bronchitis increases.[480 481] There is consistent and

compelling evidence that ETS is a risk factor for induction of new cases of asthma.[212 255 502] A recent meta-analysis estimates that 8-13% of all cases of asthma in children younger than 15 years are attributable to household smoking.[503] In employees in restaurants and bars, the group studied the most extensively, exposure to ETS reduces pulmonary function and increases respiratory symptoms such as cough, wheezing and shortness of breath.[504 505] It has been shown that after implementation of a smoking ban these symptoms decrease significantly.[506] A study by Bates and others found that workers in premises permitting customer smoking reported a higher prevalence of respiratory and irritation symptoms than workers in smoke-free workplaces. Concentrations of salivary cotanine found in exposed workers have been associated with substantial involuntary risks for cancer and heart disease.[155] Adults with asthma often experience an exacerbation of symptoms when exposed to ETS.[507] As reported by Howard *et al.*, the course of arteriosclerosis is not only accelerated by active, but also by passive smoking. In middle-aged smokers, the disease proceeds 50% faster than in non-smokers; in ex-smokers and passive smokers this value is 25% and 20%, respectively.[508]

There is also increasing evidence that ETS causes heart disease[2 213 255]. A study by Glantz and Parmley and another study from Finland document how the stay in smoke-filled rooms can increase the risk of coronary heart disease, with those most exposed experiencing up to a 30% increased risk of myocardial infarction.[509-511] One mechanism is thought to be endothelial dysfunction of the coronary circulation[512] although, while there seems to be a clear dose-response effect, with greater exposure to ETS associated with greater risk of death from heart disease[509], even short-term exposures to ETS can increase the risk of coronary thrombosis by increasing blood platelet aggregation and an increased need of oxygen by the heart.[2 509 513] Longer-term exposure causes plaque build-up in the arteries. As a result, exposure to passive smoke raises coronary death rate by approximately 20-70%.[513] A meta-analysis by He and colleagues[514] focuses on the risk of coronary heart disease associated with passive smoking among non-smokers. Overall, non-smokers exposed to ETS had a relative risk of coronary heart disease of 1.25 [1.17-1.32; CI 95%], compared to unexposed non-smokers. In case-control studies the risk was higher (1.51 [1.26-1.81]) than in cohort studies (1.21 [1.14-1.30]). The authors identified a significant dose-response relation dependent on the amount of cigarettes non-smokers were exposed to. A meta-analysis by Law, Morris and Wald[515] estimated the excess risk from ETS exposure as 30% (22-38%, CI 95%) at age 65 years.

Non-smokers that have been exposed to ETS show an increase of carbon-haemoglobin in their blood, leading to oxygen depletion in the body. This exerts significant adverse effects on the exercise capability of both healthy people and those who suffer from heart disease.[509] Especially for the latter this may be problematic, but also for those who have to perform tasks that require concentration. Interestingly, however, according to the results of a review of ten epidemiological studies, non-smokers appear to be more sensitive to ETS than smokers with regard to cardiovascular effects. The results further suggest that ETS does not only cause heart disease, but this increase in risk translates into about ten times as many deaths from ETS-induced heart disease as lung cancer.[509]

There is also evidence linking ETS to other adverse effects in adults, including stroke[516], exacerbation of asthma, reduced lung function, and respiratory symptoms, but the associations have not proven yet to be causal.[213 255 517]

More recent studies[155 262] use nicotine and its metabolite cotinine as measures of tobacco smoke intake for assessing exposure levels and effects of ETS (measurement of concentration in serum and urine of non-smokers). Although cotinine provides only a measurement of exposure within a few days and cannot capture the long-term exposure to passive smoking[4], it has been shown that concentrations of serum and urinary cotinine increase significantly with ETS exposure –

for example in employees of the catering business, or in life partners (mostly the wives) of heavy smokers.[261 518] The amount of ETS exposure of a non-smoker depends on the number of smokers in the indoor environment, the intensity of their smoking (number of cigarettes), the duration of exposure, the volume of indoor environment and ventilation characteristics, the breathing pattern, and the activity of the non-smoker.[171 483 489]

In general, exposure levels to ETS is still high. Homes, workplaces, and public places are all sources of ETS exposure.[4] According to Hackshaw, about one in every six non-smokers in Britain are exposed to tobacco smoke from smokers at home.[262] The WHO estimates that about 700 million, or almost half, of the world's children breathe air polluted by tobacco smoke, particularly at home.[498] Hospitality industry employees are exposed to ETS at levels 1.6 to 6.1 times higher than in other workplaces and 1.5 to 4.5 times higher than in a residence with one or more smokers.[519] Given the fact that these employees often spend 30 to 40 hours (or even more) a week in smoke-filled environments, the rate of lung cancer may be 50% higher, and the rate of cardiovascular disease up to 70% higher than in the general population.[519] A recent study from the United Kingdom came to the alarming results that every week one hospitality worker would die due to passive smoking.[156]

Compared to all these consequences, the immediate effects of involuntary intake of tobacco smoke – such as headache, dizziness, burning of the eyes, difficulties of breathing, and cough – may seem to be rather "harmless" but should not be ignored as contributions to the health hazards experienced by non-smokers. However, particularly in view of the serious health consequences and the high prevalence of cigarette smoking in the population, the enormous negative impact on public health should be sufficient to justify measures to restrict smoking in all public places and workplaces, and to discourage people from smoking in their homes in ways that place others at risk.[262 264]

For Austria, a cautious estimate assumes that in 2003 1,412 people died as a consequence of passive smoking.[256]

Women and smoking

Several studies, particularly the major study of Fontham and others[260] and the 2001 Surgeon General's Report on smoking and women[206], on which this chapter draws extensively, arrive at the conclusion that women smokers, apart from the risks they share with male smokers (such as increased risk of cancer, cardiovascular disease, and pulmonary disease) also experience specific risks related to menstrual and reproductive function. Female smokers taking oral contraceptives do also have a higher risk of thrombosis, heart attacks, stroke or cerebral haemorrhage.[6 238 239]

In the U.S., already far more women are dying of lung cancer than of breast cancer each year. The most important health consequences of smoking specific to women have been found to include higher risks for: lung cancer; other cancers (such as cervix, oropharynx, bladder, liver, colon, pancreas and kidney); cardiovascular disease (particularly coronary heart disease, ischemic stroke, subarachnoid hemorrhage, peripheral vascular atherosclerosis); chronic obstructive pulmonary disease (COPD) and impaired lung function; menstrual dysfunction; conception delay, primary and secondary infertility, ectopic pregnancy, lower bone density and increased risk of hip fracture; and other conditions such as cataract, age-related macular degeneration, and possibly also depression. Among pregnant women, smoking during pregnancy in-

creases the risk of miscarriage, placenta ablation, other pregnancy complications, pre-term birth, low-birth-weight infants and stillbirth. Among offspring of smoking mothers, the risk of infant mortality and sudden infant death syndrome (SIDS) is significantly increased.[2 6 206 520-526]

In general, the risk of many diseases increases with quantity, duration, and intensity of smoking. On the other hand, giving up smoking reduces the risks considerably, no matter at what age women stop smoking. For example, the risk of coronary heart disease is substantially reduced within 1 or 2 years after giving up smoking, and the risk for stroke approaches that of a woman who never smoked after about 10 to 15 years smoking cessation. Pregnancy is a specially risky period and women are more likely to stop smoking during pregnancy, both spontaneously and with assistance, than at other times in their lives.[206]

Smoking cessation and nicotine dependence

No matter at what age one stops, smoking cessation decreases health risks.[263] Some excess risks due to smoking are significantly reduced within a very short time. For example:

Smokers who quit before the age of 50 halve their risk of dying in the next 15 years.[263] The risk of coronary heart disease is substantially reduced within 1 or 2 years after cessation[206] and the risk of a heart attack is halved (or more) within a year of stopping, subsequently slowly declining further. Stopping after a heart attack can halve the chance of suffering another one. Fatality from stroke decreases significantly within 2 years and reaches the risk for non-smokers after 5 years[6], according to other estimates with regard to women after 10 to 15 years[206]. The risk of pancreatic cancer returns to that of non-smokers after 5 years of quitting.[6] Smoking during pregnancy reduces birth weight. However, with successful cessation by the third trimester, much of the weight reduction can be avoided.[263] Female smokers who take oral contraceptives have a higher risk of heart attacks, stroke or cerebral haemorrhage. After stopping the risk from all these sources immediately falls.[6]

However, due to the highly addictive character of nicotine, leading to tolerance (diminished response to repeated doses of nicotine) and physiological dependence (resulting in withdrawal symptoms, such as craving for nicotine, impaired ability to concentrate, disrupted cognitive performance, mood changes, and impaired brain function[527], many quitting attempts are unsuccessful. Very often, smoking cessation can be described as a dynamic, cyclic and complex process involving several stages. The trans-theoretical model of Prochaska and colleagues[466 467] conceives behavioural change as progress through five stages: pre-contemplation, contemplation, preparation, action, and maintenance (6 months after stopping smoking).

APPENDIX M

Laws and regulations for tobacco control measures in Austria

Laws on smoking restrictions in public places

Schools

Article 9.(2) of the school regulations[528] forbids pupils under 16 years of age from smoking within school buildings or other educational facilities. However, smoking may be permitted by pupils aged 16 years and over in clearly specified parts of the school (e.g. in a courtyard or in front of the school entrance)[a]. Permission to smoke can also be given for school events but not where pupils are being taught. Teachers may smoke in staff rooms.

Allowing pupils aged 16 years and over to smoke in parts of the school signals that smoking is associated with maturity, a policy that contrasts with the approach taken in youth campaigning in recent years. Interestingly, the initial draft of the 2003 amendment of the tobacco law contained a comprehensive ban in schools and provisions for sanctions but in a letter from the Ministry for Health and Women, in July 2003, the first draft was dismissed as "erroneously sent", with the mistake ascribed to the pressure to implement EC directive 2001/37/EC. To ensure its implementation "as soon as possible" (with already one year delay, see Chapter 8), the regulation had thus to be interpreted more narrowly and the initial proposals had to be cancelled.[364] Elisabeth Gehrer, Minister for Education, is also strictly opposed to a complete smoking ban in schools *(Chapter 9)*.

Workplaces

Although rather vaguely formulated and not always adhered to, smoking in the workplace (the catering business excluded) has been regulated since 1983. According to the 1983 General Employees' Protection Law *(Allgemeine Arbeitnehmerschutzverordnung, AAV)*[530], non-smokers are to be protected from the effects of tobacco smoke by "appropriate technical or organisational measures, as far as the kind of enterprise or the organisation of the enterprise allow for it". Such measures include increased ventilation, separation of smokers and non-smokers, and smoking bans in specified areas.

On EU accession, Directive 89/654/EEC, which regulated the protection of non-smokers in communal areas, had to be transposed to national law and protection of non-smokers was introduced with the 1995 Employees' Protection Act *(Arbeitnehmerschutzgesetz)*[276]. Abolishing the former regulations, the new law stated that employers were bound to protect non-smokers from the effects of tobacco smoke – though still only "as far as possible according to the type of enterprise" [30.(1)]. If smokers and non-smokers have to work together in a setting used only by

[a] While in the 1980s there were specified "smoking rooms" in schools, these were abolished following a complete smoking ban in schools in 1995 under the former Minister of Education, Erhard Busek. Since 1996, however, smoking may be allowed by the rules of the house *(Schulordnung)* in certain areas of the school outdoor premises. However, some schools are known to provide indoor premises for pupils to smoke, even if it is against the law, to prevent them from crowding in front of the entrance door and endangering them from traffic[529] or, so State Secretary of Health, Reinhart Waneck, to bring them closer to "drugs"[350].

company members, smoking in the workplace is forbidden "unless non-smokers can be protected from the effects of tobacco smoke by increased ventilation of the room" [30.(2)]. This regulation can only enjoin employers and employees; a general smoking ban cannot be established. Thus the smoking ban only applies to workplaces exclusively used by employees, but not to restaurants, cafés etc. where customers smoke.[b] In addition, as agreed in negotiations among the interest groups concerned, this regulation should only apply if non-smokers are not "sufficiently protected" by increased ventilation of the room.[531] The 2001 Employees' Protection Reform Act[532] re-formulated Paragraph 2 and introduced a general smoking ban in company premises. The exemption of "sufficient protection by increased ventilation" was dispensed with and now an absolute smoking ban applies to all rooms where smokers and non-smokers work together. However, this still applies only to company employees, and restaurants and similar establishments remain excluded. In its 2001 version, the law further demanded that "appropriate technical or organisational measures" should protect non-smokers from the effects of tobacco smoke in rest rooms [30.(3)] and smoking is forbidden in first-aid rooms and locker rooms [30.(4)].

Despite the two amendments in 1999 and 2001 and the positive development of Paragraph 2, the formulation of the law remains vague and non-committal[c] and excludes employees in the hospitality industry and similar enterprises where customers may smoke. Except in rooms where work takes place, the law emphasises "sufficient ventilation" to protect non-smokers from the effects of tobacco smoke. There is no special protection for pregnant employees, whether in rest rooms or restaurants. For some reason, a smoking ban in locker rooms seemed more important.

Similarly, violation of the law is tolerated. There are no explicit provisions for sanctions (apart from the general administrative sanctions for failures of safety at work, under which Article 30 falls).[281] Non-smokers who feel harassed by their smoking colleagues or are not happy with the ventilation can ask anonymously for an inspection of their workplace by the *Arbeitsinspektorat* (Regional Labour Inspectorate) which would result in a consensual meeting between all those concerned.[275 281] As expressed in a letter from the Ministry for Economic Affairs and Labour, a "consensual" agreement is seen as much more effective than a punishment.

> "Past experience of the *Arbeitsinspektorat* with this problem shows that effective and long-lasting solutions for the protection of non-smokers in their workplace can be best achieved when identified and agreed upon all those concerned in a consensual way."[281]

According to the Austrian 1997 smoking survey one in three employees is exposed to passive smoking at the workplace, and more than one third of those exposed feel harassed by their colleagues' smoking. In addition, non-smokers are clearly the majority, and object to others who smoke near them. Many smokers declared they would reduce consumption or even refrain from it if they were not 'socially cued'.[11]

In general, however, awareness of passive smoking remains low in Austria and complaining non-smokers are rarely taken seriously. In government buildings, for example, where smoking is banned, smokers do smoke in their workplace even if the smoke gets into the rooms of non-smokers, without even asking the latter if they would feel disturbed. Smoking in so-called "social rooms", which in reality are very often "smoking rooms", corridors and stairways is also common. The futility of non-smokers complaining and the righteousness of smokers was made

[b] This seems to be an adverse justification: While in other countries smoking in restaurants is banned to protect employees (and other customers), in Austria smoking obviously *can not* be banned because of the customer's rights.

[c] Although this is not accepted by many officials who cannot imagine a law to be "even more" strict.[275]

clear in an episode when a copy of the respective Paragraph of the Employees' Protection Law was torn down within two minutes after it being affixed in the extremely smoke polluted "social room" and kitchen of a health department of the Vienna City Administration. An employee, whose duties extend also to this room and who reacts adversely to tobacco smoke with red and sometimes inflamed eyes, was attacked for being "hysterical" and a struggle involving opening and closing of windows ensued.

Hospitals

According to Article 6.(1) lit.e of the 1974 amendment of the 1957 Hospital Act *(Krankenanstaltengesetz, KAG)* regulations on smoking are the responsibility of the hospital's management. What restrictions exist are therefore not due to the tobacco law.[533]

Article 10.(1) lit.h of the 1987 Vienna Hospital Act 1987, for example, specifies that, based on the patients' rights, smoking in hospitals should be banned; however, specified areas for smokers may be accepted. In reality, these specified areas are usually the entrance halls, the reception areas, the cafés within the hospital, and very often the nurses' rooms. Again, sympathy is immediately directed towards the smokers in hospitals who not only suffer from a disease but then cannot find a place to smoke.

> *"But one also has to say that one has to give patients the opportunity to smoke because, if I bar someone from a habit, this can have a negative influence on the course of disease."* (Austrian State Secretary of Health, physician: radiologist)

> *"This is a problem of addiction which, however, has an enormous effect on the patient's agility, to get up for a smoke. One cannot put seriously ill patients on withdrawal."* (Vienna City Councillor for Health, physician: internal specialist)

While it is clear that many smokers are addicted to nicotine, experience from other countries shows that it is possible to make hospitals smoke-free, where necessary establishing mechanisms for patients who are most addicted to received nicotine replacement therapy.[534] [535]

Laws on advertising, promotion and sponsorship

The 1995 Tobacco Act restricts advertising for tobacco products, although its provisions are weaker than in some other countries. According to Article 11, advertisement of tobacco products containing more than 10mg tar is prohibited from 1 January 1997; advertisement for cigarettes without filters is banned completely. Giving free samples and selling at below-cost are also prohibited. Press advertising is restricted to no more than one advertising page per periodical per manufacturer. Radio and TV advertising is prohibited entirely. Poster and cinema advertising must contain information on health risks of tobacco consumption and are subject to other restrictions: Posters must not exceed the size of 16 sheets and are not allowed to be placed in proximity to schools and youth centres; cinema advertisement for tobacco products is only allowed in the context of G-rated films. Sponsorship of events, groups or associations, including publicity about sponsorship, has to comply with the same regulations as advertising.

The content of advertisements is also subject to specific restrictions. For example, advertising for tobacco products must not be targeted towards young persons; models must not be or appear younger than 30 years of age; the portrayal of well-known athletes, the portrayal, naming, painting or caricaturing of well-known persons or their statements on smoking, and the use of car-

toons is prohibited [Article 11.(3)]. As various cigarette advertisements, the positioning of a Casablanca cartoon at the entrance of underground stations *(APPENDIX Q)* and the selection of participants in TV discussions on tobacco control measures *(APPENDIX V)* show, these regulations are not always adhered to.

Since 1995, foreign tobacco companies have been allowed to promote their products directly in Austria. However, advertising for foreign tobacco products is restricted to foreign papers and magazines distributed in Austria.[d]

The provisions of the recent European Commission directive 2003/33/EC and recommendation 2003/54/EC will restrict advertising further in print media, radio, electronic information, and sponsorship. These regulations, however, do not represent a complete advertising ban, as, for example, indirect advertisement and advertisement on billboards is still allowed *(APPENDIX I)*.

Laws on product control and consumer information

Recent EC regulations, as implemented into the Austrian law, reduce the maximum tar and carbon monoxide yield of cigarettes to 10mg and the nicotine yield to 1.0mg from 1 January 2004 onwards. By 1 January 2007, this will also apply to cigarettes produced in Austria but for export outside the EU.

The front of each cigarette pack and any outside packaging has to carry the warning "Smoking can kill" or "Smoking seriously harms you and others around you", in the German language. An additional warning from a list of 14 agreed wordings, used in rotation, has to appear on the flip side of cigarette packets, and on any outside packaging. The warnings are in accordance with the tobacco products directive 2001/37/EC *(APPENDIX I)*.[e]

[d] In the past, the fact that German magazines and newspapers were distributed in Austria was used as an argument against the feasibility of an advertising ban in Austria (for example, under Health Minister Salcher in 1980 and Health Minister Löschnak in 1988 – *see Chapter 9 and APPENDIX S*).

[e] However, label number 10: *Get help to stop smoking: (telephone/postal address/internet address/consult your doctor/pharmacist) (APPENDIX I)* will be difficult to implement, as no such helpline or information centre exists. In addition, there is no special training in smoking cessation for doctors, apothecaries, or other health professionals to assure a reliable quality level.

APPENDIX N

Taxes and duties for tobacco products in Austria

With EU entry on 1 January 1995, tobacco taxation has been reorganised and changed from an ad valorem tax system to a composite tax rate. In 1995, excise taxes amounted 232 ATS (= €16.9) per 1000 cigarettes plus 41% of the retail price; at least, however, to be 740 ATS (= €53.8) per 1000 cigarettes. Since August 2002, the excise tax has been €21.38 per 1000 cigarettes plus 42% of the retail price; at least, however, taxes have to add up to €75 per 1000 cigarettes. This means an increase of taxes for cigarettes by more than one third between 1995 and 2002. Within only one year, taxation on a pack of cigarettes has risen from 57% in 1996 to 73.7% in 1997.[72] In contrast, the taxes for other tobacco products remained more or less the same.

Table N-1 Taxes and duties for tobacco products in Austria before and after EU entry

Cigarettes	Cigars	Fine-cut	Others (pipe etc.)
Before EU entry			
55% of retail price	13% of retail price	47% of retail price	34% of retail price
1 January 1995 (EU entry)			
232 ATS / 1000 cigs + 41% of retail price at least 740 ATS / 1000 cigs	13% of retail price	47% of retail price	34% of retail price
1 June 1996			
246 ATS / 1000 cigs +41.5% of retail price at least 740 ATS / 1000 cigs	13% of retail price	47% of retail price	34% of retail price
1 January 1997			
246 ATS / 1000 cigs + 42% of retail price at least 825 ATS / 1000 cigs	13% of retail price	47% of retail price	34% of retail price
1 June 2000			
255 ATS / 1000 cigs + 42% of retail price at least 825 ATS / 1000 cigs	13% of retail price	47% of retail price	34% of retail price
1 January 2001			
263 ATS / 1000 cigs +42% of retail price at least 896 ATS / 1000 cigs	13% of retail price, but at least 450 ATS / 1000	47% of retail price	34% of retail price
1 January 2002			
€ 19.11 (= ATS 263) / 1000 +42% of retail price at least € 65 / 1000 cigs	13% of retail price, but at least € 32.7 (= 450 ATS) / 1000	47% of retail price	34% of retail price
17 August 2002			
€ 21.38 (= ATS 294) / 1000 + 42% of retail price at least € 75 (= 1,032 ATS) / 1000 cigs	13% of retail price, but at least € 32.7 (= 450 ATS) / 1000	47% of retail price	34% of retail price

Source: Austrian Federal Ministry of Finance.

With regard to the directives of the European Commission, Austria's overall minimum excise duty (57.90%, including specific and ad valorem tax, but excluding VAT) is slightly above the 57% minimum excise duty adopted by the Council in 1992 (amended in 2002). The highest

minimum tax levels are in the United Kingdom (65.5%), but also in Portugal (62.7%), Ireland (62.0%), and Denmark (61.7%); the lowest in Sweden, Belgium and Luxemburg.

The total tax (comprising specific tax, ad valorem tax and VAT) on cigarettes in Austria is 74.6% of the retail selling price (all taxes included), which is about European average. The highest total tax levels are in Denmark (81.7%), the UK (80.4%), Ireland (79.3%) and Portugal (78.7%), the lowest in Luxemburg (67.7%) and Sweden (69.9%).[536]

Table N-2 Cigarette taxes in EU Member States

Member State	Total Tax (specific + ad valorem + VAT) as % of TIRSP[1)]	Excise Yield EUR per 1000 pieces	Overall Minimum Excise Duty (specific + ad valorem, exclud. VAT)
AT	*74.57 %*	77.84	*57.90 %*
BE	*74.36 %*	80.25	*57.00 %*
DE	*72.50 %*	92.70	*58.71 %*
DK	*81.67 %*	124.40	*61.67 %*
EL	*72.75 %*	67.50	*57.50 %*
ES	*72.02 %*	53.86	*58.23 %*
FI	*75.60 %*	115.20	*57.56 %*
FR	*75.38 %*	106.18	*58.99 %*
UK	*80.42 %*	229.79	*65.53 %*
IE	*79.34 %*	155.04	*61.98 %*
IT	*74.67 %*	59.91	*58.00 %*
LU	*67.72 %*	59.35	*57.01 %*
NL	*74.10 %*	82.31	*58.14 %*
PT	*78.71 %*	61.17	*62.74 %*
SE	*69.87 %*	96.06	*49.87 %*
Minimum excise duty adopted by the Council on 19-10-1992 [2)]			57 % of the TIRSP [1)]

1) TIRSP = Retail Selling Price, all taxes included.

2) Dir. 92/79/EEC last amended by Dir. 2002/10/EC.

Source: European Commission, Excise Duty Tables.[536]

APPENDIX O

Anti-smoking campaigns in Austria since 1980

Health Ministry

1980 ***Ohne Rauch geht's auch – Eine Aktion des Gesundheitsministers.***
(Same without smoke: An Action of the Health Minister)

On 17 November 1980, the former Austrian Health Minister Herbert Salcher announced the first anti-smoking campaign in Austria, starting at the very same day. This campaign was conducted with an expenditure of only about ATS 7 million (€500,000)[a] and encompassed three phases. As a first step, radio and television spots and advertisements in all newspapers were released at once, followed by posters in mid December and cinema spots from 20 December onwards. Subsequently, a quitting programme called 'Life Support' was conducted by physicians from 10 January onwards. This support programme was meant to become a permanent institution, including the establishment of information centres where 'patients' obtained so-called 'quit-sets', consisting of anti-smoking literature and various questionnaires taking account of the personal problems of the various types of smokers.[337 b]

The declared goals of this first anti-smoking campaign were to keep non-smokers as non-smokers, to transform smokers into ex-smokers, and to protect non-smokers from smoke. Already in 1980, there was concern about the increasing smoking rates among young people, particularly among young women.

Salcher also expressed his deprecation for deterrent advertising, picturing smoking legs dripping with blood or open lungs (black smoker's lung), intended to shock. Similarly, long lists of diseases and ailments following tobacco consumption were seen to result only in short-term nicotine abstinence, at best. Rather, for a long-term perspective, a positive image for non-smokers should be promoted or created.[336]

The chosen slogan of this campaign had become very popular and kept up for a long time, although the campaign itself was rather short. The campaign was also accompanied by a survey, the results of which were published in 1982.

1985 ***Ohne Rauch geht's auch*** **– Follow up campaign**

On 1 June 1985, a follow-up campaign was started, using the same slogan. It was set to run for four to six weeks. The campaign was conducted by the Austrian Pharmacists' Association, the Austrian Physicians' Association, the Association for Health Education and Health Information, and the Federal Ministry for Health and Environmental Protection. The campaign aimed to make people aware of the health hazards of smoking and, more

[a] The very low costs of this campaign may also be attributed to the co-operation of the media which charged nothing for their really frequent TV and radio spots and newspaper advertisements. This was due to the team around Minister Salcher, comprising also a young and very popular radio speaker, and the engagement and daily contacts of Minister Salcher to the Austrian media, appealing to the "good will" *(Chapter 9)*.[305]

[b] No information as to how that worked and what became of it could be obtained from the responsible key informant due to lack of time on his part for almost exactly one year (end of study).

specifically, to prevent people from starting to smoke. It included posters, information brochures, and 20-second radio and television spots. A kind of handbook entitled "Therapy for Smokers", described various cessation techniques and was distributed as part of the campaign.

This repeated campaign was inspired by a study by the Federal Health Ministry "Smoking and Health in Austria – 5th Report 1984", reporting that in the period 1981 to 1984, after a first drop of smoking rates, smoking increased from 22% to 28% among women and from 33% to 43% among men.

1990 **Smoke Off**

This was a rather small campaign, targeted at youths who preferably had not started smoking yet. It was launched at the occasion of the 3rd World No Tobacco Day with its motto 'growing up tobacco-free' and conducted by the Ministry of Health in co-operation with the Ministry for Education. The aim of this campaign was a trend reversal towards 'smoking is out'. Health Minister Harald Ettl pointed to the hazards put at children by smoking parents. [294]

According to the advertising agency, the image to be transported should be a strong, self-confident, independent, freedom-loving, humourous, sportive, sociable, and modern youth. In fact, this image is identical with that advertised for smokers. However, a survey among youth reported that the 'undesirable' characteristics ascribed to non-smokers would be good, well-behaved, conform, unsociable, puritanical and health conscious.[294]

The campaign, therefore, features 'ideal conform' youths on posters and in cinema film clips to signal to their peers on an 'emotional level' that smoking is 'out'. A radio spot should support these efforts. The strategy was to strengthen non-smokers without defaming smokers, so Health Minister Ettl.[294] Critics argue that these posters, picturing a young male or female with a 'Smoke off' sign, subtitled with the name of the youth, her/his age, and her/his main characteristic: non-smoker, would not be enough to motivate peers to copy this ideal.[537] In addition, the slogan itself (why in English language?) is possibly not very well chosen and it is not quite clear what it should express exactly (neither in English nor in German language). It sounds a bit like what adults think that modern young people like.

The budget of this campaign was very modest with only ATS 3.5 to 4 million (i.e. €250,000 to 290,000); therefore, one had to rely on sponsors.[294] However, no information could be obtained as to who were the sponsors.

From autumn 1990 onwards, this initiative was accompanied by a 'media package' by the Ministry for Education, showing video films staring youths interviewing critically ill smokers, and a tuitional folder discussing issues such as motives for youths to smoke, cigarette advertising, and the effects of nicotine and cigarette ingredients.[294]

1994 ***Miteinander ohne Rauch***
(Together without smoke / Getting along together without smoke)

This campaign was initiated by the former Health Minister Michael Ausserwinkler, who had to face massive difficulties and harassments from the tobacco industry, the media, the opposition party and even members of his own party. The campaign aimed to point to the

dangers of passive smoking, especially for children and un-born, and appealed to the consideration of smokers.

The campaign primarily consisted of an informative brochure entitled "Getting Along Together Without Smoke – First Aid for Smokers; First Aid for Non-Smokers" *(Miteinander ohne Rauch – Erste Hilfe für Raucher; Erste Hilfe für Nichtraucher)*, published in 1993. A new edition followed in 1995 when the campaign was repeated.

The brochure offered information on the harmfulness of smoking, information on passive smoking, a questionnaire on type of smoker and reasons for smoking, references to smoker information centres in various Austrian cities, arguments for 'co-smokers' (passive smokers), information on different kinds of passive smoking and risks of diseases. The aim of this brochure was to contribute to an increased awareness of the dangers of both smoking and passive smoking, to increase the sense of responsibility of smokers for themselves as well as their 'co-smokers', and to encourage non-smokers to defend themselves. For those willing to withdraw from smoking, consultation and help is offered (e.g. information centres for smokers). In addition, lists of therapeutic offers were compiled and distributed to doctors, apothecaries and psychologists.

This campaign (or rather, the brochure the campaign mainly consisted of) was primarily thought to promote the contended tobacco law, as legal measures were recognised to be essential for a successful tobacco policy. Therefore, one of the most important target groups were political opinion leaders. The costs for this campaign were about ATS 20 million (€1.5 million).[277]

1995 The campaign was repeated, but with less money.

1998 **Smoke Sucks**

The basic funding for this campaign came from the Austrian tobacco company, the then *Austria Tabakwerke*.[308] The campaign is designed as a concept of partnerships, particularly with co-ordinators of youth organisations and organisers of concerts and sports events, and should run for several years, starting in 1998. It was based on a study in adolescents who were said to take up smoking at an average age of 11.5 years. The highest increase of regular smokers was registered at teenagers aged 15 to 16 years. The aim of this campaign was to postpone first attempts of smoking and the start of regular smoking for as long as possible, and generally prevent 10 to 14 year olds and teenagers from smoking.

Both the slogan[c] of the campaign, the symbols (e.g. a raised middle finger in the form of a cigarette), and the various posters and pictures of teenagers were not at all appealing, and the campaign certainly had no effects on youth. It may even be assumed that it had the effect of making smoking appear really "cool".

2002 ***Ich (b)rauch(s) nicht = Ich brauchs nicht / Ich rauch nicht***
(I don't need it / I don't smoke)

This campaign was conducted from September to December 2002 by the Fund for a Healthy Austria, commissioned by the Austrian Ministry for Health and Women *(see later)*.

[c] Whatever the English slogan might suggest, it is badly chosen and a German translation sounds even worse.

2002–2005 **Feel Free to Say No**

Starting with the World No Tobacco Day in May 2002, this three-year EU campaign is conducted in Austria by the German advertising agency Media Consulta. The Austrian Ministry for Health and Women acts as the national contact; its primary role, however, seems to be confined to collect the reply cards for a contest.[308] This campaign, too, focuses on teenagers and the creation of awareness towards smoking.[538]

2003, implementation school-year 2004/05 ***Rauchfreie Schule*** **(Smoke-free school)**

Commissioned by the Ministry of Education, Science and Culture and in cooperation with the Ministry for Health and Women, the Ludwig Boltzmann Institute for Medical Sociology conducts this project entitled "Smoke-free school. Democratically against smoking. Guideline for the implementation of tobacco regulations in schools".[308 539] Schools have been found to be the place were smoking happens most frequently. This guideline should therefore support schools in developing effective and socially acceptable regulations against smoking in a democratic process. All schools are invited to participate.[540]

2004 ***Rauchfrei ab Mai*** **(Smoke-free from May onwards)**

Conducted within the framework of the international initiative "Quit and Win", in cooperation by the Ministry for Health, Austrian Medical Chamber, Austrian Chamber of Pharmacists, Austrian Association for Lung Diseases and Tuberculosis, the pharmaceutical company Pfizer.

Fonds Gesundes Österreich (Fund for a Healthy Austria)

The *Fonds Gesundes Österreich (FGÖ)* was initiated in October 1998, based on the Austrian Health Promotion Law of February 1998. The fund works in cooperation with the Health Ministry, which is also the main financier. The funding is based on a certain share of tobacco taxes (for tobacco products purchased from outside the EU). However, the anti-smoking activities of the FGÖ may be called very modest. The Fund is presided by the State Secretary of Health, Reinhart Waneck.

2002 ***Ich (b)rauch(s) nicht*** **(I don't need it / I don't smoke)**

This recent and very short campaign, lasting from September to December 2002, was part of a more comprehensive lifestyle campaign, comprising diet, physical activity and mental health. The initiative was targeted towards young people aged 11 to 18 years, but focuses on the 11 to 14/15 year olds. It is a media campaign, conducted by an advertising agency, comprising posters, advertisements in cinema and TV, but offers also activities on location (e.g. within the frameworks of 'healthy communities', health promotion institutions in the provinces, and the youth red cross). However, no activities take place in schools, as this is done by another campaign of the Austrian Cancer Society *(see below)*.

The focus of this campaign was on teenagers and the creation of awareness. The campaign was very scene-oriented, working with prominent sportsmen and -women who should function as role models, and young, self-confident and 'positive' young people pictured on posters etc. Part of this campaign was the active participation of the teenagers. This campaign is regarded as the Austrian contribution to the EU-wide efforts to tackle smoking among children and youth.[279 307 541 542]

Austrian Cancer Society

1999 **Don't start, be smart**

This campaign has been running since 1999 and was mounted to target young people, trying to prevent them from taking up smoking by a competitive setting. The Austrian Cancer Society has been inviting school classes with pupils aged 13-14 years to take part in the Europe-wide "Youth-Non-Smoker-Competition". From 2002 onwards, all pupils aged 11 until leaving school have been included in the target group of this campaign.

The campaign should motivate adolescents for a smoke-free term (semester) and, according to information from the Society, it proved rather successful. Teachers and medical school officers are also invited to give information and to launch projects. Since 2002, information on the internet has also been available. An educational information leaflet entitled "Fag news for fans and non-smokers" is addressing tobacco facts, concluding with a kind of questionnaire.

Independently from the campaign, the Austrian Cancer Society also issues a brochure for smokers and non-smokers ("Non-Smokers! – Information by the Austrian Cancer Society"), including information on health risks, supposed reasons for smoking, and tips for giving up smoking.

On the regional or local level, there are a few institutions, organisations or local health promotion associations, which provide information or have set initiatives. They are, however, very few and concentrate in Austria's most western province Vorarlberg. Activities there include:

- The *Werkstätte für Suchtprofilaxe* (SUPRO, Vorarlberg) offers workshops and seminars where information is offered with regard to all substances, among them also nicotine. Information covers effects, dangers, reasons for consumption, social dimensions, etc. These offers can be requested by schools or other institutions.
- The information centre and helpdesk *Clean* (Vorarlberg) offers consultancy for drug-users who want to quit. Smokers, however, form only a very small proportion of the clients.
- The new *Supro Mobil* (Vorarlberg) is meant for secondary prevention of drug consumption among young people. Teenagers are actively approached at youth events.
- In 2002, the *Arbeitskreis für Vorsorge- und Sozialmedizin* (AKS, Vorarlberg) has organised courses and seminars for adults who wish to give up smoking. The activities were advertised in magazines and journals, trying to target all adults.

In Tyrol, the educative talks by Robert Rockenbauer, editor of the only Austrian non-smokers' magazine, in schools have to be named.

APPENDIX P

Cigarette smuggling in Austria

Over the last three years, between 60 and 80 million cigarettes have been confiscated every year in Austria and the figure is increasing by about 20% per year. In 2002, a total of 22,300 cases of cigarette smuggling were registered, of which 22,000 cases were small-scale and 300 large-scale affairs – the latter, however, accounting for 70% of the overall volume confiscated.[324]

Compared to the past, where cigarette smuggling mostly involved individuals (cross-border shopping), the organised and large-scale smuggling by large gangs currently forms the greatest share and continues to increase. Since 1995, the number of confiscated cigarettes has been rising markedly. This is being attributed primarily to transit through Austria to the United Kingdom, although this trade is thought to be decreasing because of a shift to the sea route. According to the Austrian Ministry of Finance, more than 90 million cigarettes were confiscated in 2001, and about 60 million in 2002.[a] The smuggling of Austrian cigarettes is reported to be increasing.[325]

Of the confiscated goods, the share of genuine brands is less than 10%. These are first exported duty-free to other EU countries (mainly to Italy) before being smuggled back to Austria or other EU countries. The main brands destined for Austria are *Memphis* and *Milde Sorte*, but also *Marlboro* and *Ernte*. The majority, however, are counterfeit brands made in China, an increasing problem over the last two or three years. At first, *Marlboro*, the world's number one brand, was the main brand being counterfeited; now, however, there are others. Most are destined for the UK (especially *Benson & Hedges* and *Super Kings*), fewer are destined for Germany and Italy. Only about 10% are destined for Austria.[324]

In Austria, the black market share is estimated to be no more than 10%. By comparison, in the UK, the black market share has been about 40% although this has now fallen to 20 to 25%.[324] Although the argument is unjustified, this high black market share in the UK is often used to challenge price rises in Austria.

In the mid 1990s, smuggling was estimated to cost the Austrian economy between ATS 2–3 billion (€143–214 million) annually, with *Austria Tabak* and the retail trade incurring losses of about ATS 0.5 billion (€36 million) each.[72] More recent information was sought from *Austria Tabak*, but was not provided by the company. Throughout the European Union the economic loss due to cigarette smuggling is estimated by the European Anti-Fraud Office (OLAF) to be €20bn per year.[324]

Austria Tabak takes the standard industry line that a major reason for smuggling is the difference in price between Austria and its eastern neighbours, or between the European Union and the acceding member states that have low price levels. The company claims that it cooperates closely with the authorities to prevent smuggling.[70]

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[a] As noted, smuggling has increasingly become a matter of large-scale business, and therefore the number of confiscated cigarettes varies considerably each year.

An important indicator of the official attitude to cigarette smuggling is the nature and scale of sanctions that are in place. In Austria, cigarette smuggling is regarded as a breach of the tax regulations. The maximum sentence is three years imprisonment, which is much less than for smuggling of other (illegal) drugs. As it is highly lucrative, cigarette smuggling has become a more profitable (and less dangerous) business for many.

Although the threat of an increase in smuggling is regularly raised by the tobacco industry when the government suggests increasing taxes, some smuggling can benefit the industry in a number of ways. First, it increases the market share by stimulating consumption through the sale of cheap cigarettes (the industry profits regardless of whether the cigarettes enter the market legally or illegally). Second, as the overall goal of the industry is to keep the price low, it is a means of enabling the industry to penetrate new markets while allowing it at the same time to argue for a reduction in tobacco taxation in order to reduce the incentive to smuggle.[27 400]

However, as Luk Joossens demonstrated, the argument that high taxes increase smuggling cannot be sustained. Low income countries and countries with low tax levels have also the highest smuggling rates. For example, the share of the "tax-free"[b] market was 77% in Mali, 72% in Albania, and 68% in Iran, compared to 22% in the UK, a country with one of the highest tax levels. Weaker enforcement in the former countries seems unlikely to be the only explanation. However, it is clear that increases in taxes should be linked to enforcement of border controls.[543 544]

The tobacco industry is certainly a winner in relation to smuggling. In the Austrian cigarette market, and taking the level of smuggling into account, the tobacco industry has estimated a potential legitimate annual sales volume of 17 billion cigarettes in 1996/97.[72]

As noted in many countries, industry participation in smuggling is not unusual.[c] But officials from the Austrian customs office report no evidence that the Austrian tobacco company has been involved in any cases of smuggling.[324]

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[b] This wording, a paraphrase for smuggled cigarettes, was found in a RJR document presented by L. Joossens at the Helsinki Conference.

[c] See, for example, the case of the German tobacco company Reemtsma, at least four leading members of which were found to be involved in the illegal return transport of untaxed German cigarettes from Eastern Europe to Germany in January 2003, a multi-million euro business. In addition, Reemtsma has been linked to criminal organisations, money-laundering, and fiscal fraud.[545]

APPENDIX Q

Examples of smoking and no-smoking policies in Austria

Public transport, railway and underground stations

Austrian Federal Railways *(Österreichische Bundesbahnen, ÖBB)* have been increasing non-smoking compartments in trains for several years.[a] Very often, though, although the compartments themselves may be non-smoking, people smoke outside on the gangway. Conversely, smoking compartments are often empty, or occupied by non-smokers who could not find a seat in a non-smoking compartment.

In stations, the 1995 tobacco act only 'suggests' smoke-free zones in buildings of the public transport, "wherever this is possible/manageable". Therefore, smoke-free zones in station buildings (i.e., in waiting lounges) were first introduced only in 2000.[283] There is no general smoking ban in the public area of stations. These regulations are stipulated in the 'rules of the house' which are published on a large and not exactly eye-catching poster where one could read in small printed letters that (among other requests of the station administration) one is kindly asked to keep the place clean and be considerate.

Not surprisingly, smoking restrictions in station buildings are rarely followed by customers and are not enforced. In theory, fines for smoking in non-smoking areas of trains are possible, but amount to only €15.

An official of the ÖBB reported that restricting smoking has never been an issue for the company. However, after recovering from the surprise of being asked, he expressed gratitude for the suggestion and the reference to the tobacco law which could be used in justification of action which would then not be seen simply as responding to "demand by militant non-smokers".[283] He reckoned that, for the future, the argument of saving cleaning costs (in particular with the planned out-sourcing of the cleaning sector) might increase non-smoking zones. It may also be that knowledge that some of Germany's railway stations are already smoke-free (with special rooms for smokers) will help to accelerate the development in Austria.

The situation is different in local public transport. In Vienna, trams and buses of Vienna Transport have always been smoke-free.[b] In suburban trains[c] smoking was allowed on all trains until 1987 when first only a few but, after assurance that it would be acceptable to passengers, all wagons became non-smoking in 1991.[546] Smoking in underground stations has been banned since 17 April 1990, with the installation of sand-ashtrays with a Casablanca cartoon[d] at the

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[a] The proportion of smoking and non-smoking seats is essentially based on the UIC (*Union Internationale de Chemins de Fer*, a drawing up of guidelines for the joint utilisation of railway networks)-specifications, demanding 1 part smokers versus 2 parts non-smokers. Today, this ratio is still valid in the long-distance traffic, with the exception of some night trains where a general smoking ban exists. In local traffic, however, there is a general smoking ban at present, while in the past the ratio 1 smoker versus 2 non-smokers was applied. A few older wagons, though, which are partly utilised in the long-distance traffic, still offer smoking compartments. Local trains near the national border (e.g. Ausserfern) may also offer smoking seats.[546]

[b] Apart from the times of the Emperor in the 19th century, when trams in Vienna were provided with ashtrays.

[c] Managed by Austrian Federal Railways.

[d] Casablanca is the 10th popular cigarette brand in Austria. Although the tobacco law prohibits the depiction of cartoon figures, this is apparently a kind of tolerated exception.

entry of the inner part of the station, but customers do not fully adhere to this ban. However, stations are occasionally checked by the stationmasters and perpetrators can be fined €40. Small posters inside the stations inform the smokers about this fine *(see below)*. Although this amount is rather low[e] (the fine for fare dodgers is €60), these fines represent the only sanctions set for being caught smoking in a public place. This, however, is not based on the tobacco law but on the terms of transport.

Picture 2 *Casablanca ashtray at entrance of Vienna underground stations*

Picture 3 *Small posters in Vienna underground stations for fines for smoking.*
On the left-hand side a smiling face "costs nothing",
on the right-hand side a smiling face with a cigarette "costs €40,-".

Of course, for public transport companies, the primary intention in increasing smoke-free sections in vehicles and restrictions or bans in stations has not been considerations of health but rather of fire hazards and economic concerns (cleaning expenses etc.). The changes, as reported by an official of Vienna Transport, have also been a consequence of a general shift in opinion since the 1990s.[282] Austrian Federal Railways cited as a main reason for offering more non-smoking seats in trains the reduction of damage to the interior caused by lit cigarette butts, as well as fire prevention.[283]

[e] Until June 2002 it was only about €15.

Airlines and airports

The then privately-owned airline *Lauda Air* issued a ban on smoking on international flights between Austria and East Asia and Australia in 1988. Tyrolean Airways reports an increase of flights in the winter of 1988 following a smoking ban on all flights which was "welcomed by passengers".[547] Only more than ten years later, in March 1999, did Austrian Airlines (under sustained international pressure) follow suit, with smoking bans on all international and domestic flights by the Austrian Airlines group (i.e. Austrian Airlines, Lauda Air and Tyrolean Airways).[270 a]

Austrian Airlines claims that its decisions have been exclusively customer-oriented, although it concedes clear commercial advantages since smoking has been prohibited within planes (e.g. air filters are less polluted than before and have therefore to be changed less frequently). However, the decision to introduce non-smoking flights has not been as 'voluntary' as it might seem. Regulations in the United States and Israel, who demanded that all flights landing in their countries be non-smoking flights,[548] put considerable pressure on Austrian Airlines. The total ban took effect only in 1999 and Austrian Airlines was one of the last to comply.

At the beginning of the 'non-smoking era' on Austrian Airlines, obviously very anxious not to put off important customers, nicotine substitutes (Nicorette inhalators) were distributed free of charge to business-class customers. This turned out to be an enormous PR-success, as pointed out proudly by Austrian Airlines. "Even film teams from the United States came over to document this measure".[548]

A similar example was reported from Air France which offered free nicotine patches on long flights, thus demonstrating the degree to which smokers' needs are recognised and officially embraced.[141]

In addition, the justification by Austrian Airlines for its delay in changing to non-smoking flights, of being purely customer-oriented, seems dubious considering how, following British Airways' attempt to introduce non-smoking flights in the early 1990s, a team from Philip Morris developed a grassroots strategy to influence this anti-smoking policy.[b] This campaign was composed entirely of tobacco industry employees (in particular Philip Morris and allies), who were requested to complain about the lack of smoking seats in BA flights, after having received an instruction page and a blank sheet of paper together with their PM-issued tickets. Employees on competing airlines which still permitted smoking, were urged to write to commend their willingness to accommodate smokers.[550] It may be assumed that, as with British Airways, eco-

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[a] Austrian Airlines, which has existed since 1958, always had non-smoking areas on their flights, first with each area on different sides of the plane and later with smoking in the rear. Before the introduction of a total ban in 1999, non-smoking seats were about 60% of the total. The change to non-smoking flights occurred in stages, affecting at first short and middle distance flights and later long distance flights. Within the latter, there were differences according to destination. For example, on flights to the near and far East, the proportion of smoker-seats was higher than on flights to the United States where the non-smoking area covered 70% or more.[548]

[b] Already in May 1988, a Philip Morris team met with Mr. Michael Batt of British Airways in Heathrow, discussing BA's plan for trial runs of non-smoking flights on some domestic routes in the UK. "Mr. BATT explained that the British Airways move was entirely consumer driven. Neither he nor his colleagues had been exposed to any pressure by anti-smoking groups. ... Once the UK experiment is completed and assuming a 'favourable' outcome, BA will extend the experiment to certain routes on the European continent. The most likely candidates for this are flights to Northern European destinations."[549]

nomic considerations played a crucial role.[c] A 1989 actionplan by the German tobacco industry (VDC) to counter two smoke-free short circuit (domestic) Lufthansa flights was also reported.[551]

At Vienna Schwechat airport "smokers' corners" (more appropriate also called "smokers' islands", as they are often positioned in the middle of the non-smoking area) have been introduced since 2002, after the refusal of American airlines to land in Vienna[288]. Until then, smoking was allowed in all parts of the airport. Of course, the airport administration formulates the reasons for the introduction of smoke-free environments slightly differently, arguing that there have been increasing complaints from passengers and "oh well, the international community". In 2002, so a representative from the Austrian airport administration said, Austria "could no longer exclude itself from the international trend".[552]

Although other Austrian airports have followed suit (e.g. Linz), Vienna Airport has thus become the first public transport building where smoking is restricted to designated locations.[d] However, the number of these 'islands' have increased over recent months, contradicting the original idea somewhat. Although definitely an improvement from the past, when there were no smoking restrictions at all, these 'redeeming' corners are positioned all through the building (apart from the numerous cafés and restaurants where smoking is allowed), in particular at the gates where there are no cafés to offer possibilities to smoke.

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[c] At this 1988 meeting between representatives of Philip Morris and Mr. Batt of British Airways it was explained to the industry's delegation that "a visual separation on short-haul flights would necessitate the elimination of entire rows of seats, which would entail a financial penalty that was not justified by commercial considerations. On medium to long-haul flights, where different types of aircraft are used, such a separation is technically feasible and probably commercially beneficial. In such cases British Airways would not envisage smoking bans but would rather underline the choice offered to their consumers." The industry's representatives "made a strong presentation of PM's views including the offer for technical advice by SST".[549]

[d] Officials from Vienna Airport even asked at the Health Ministry if this was 'allowed'.[553]

Picture 4 and Picture 5 *"Smokers' corners" at Vienna Airport*

The smoking ban is only lightly controlled by the terminal supervisors who are advised to move gently anyone who is smoking outside these specified smoking corners. There are, however, no sanctions against 'culprits'. Lacking sufficient international pressure, there are presently no plans for a total smoking ban on the airport buildings.

Restaurants, pubs and bars

Internationally, within the area of tobacco and health, the most frequently discussed issue at present is whether smoking should be banned or at least be restricted in public places such as restaurants, pubs and bars[a]. Apparently, this issue is not a subject for public or political discussion as yet in Austria. Quite the contrary. Politicians, restaurant and bar owners, and the hospitality industry argue that such restrictions would be too extreme and patronising *(Chapter 9)*. Although for decades it has been assumed that a smoking environment is acceptable for the majority of the non-smoking population – including very young or very old people, people who suffer from respiratory diseases, people who react adversely to tobacco smoke, or people who just feel deeply annoyed by the smoke of cigarettes or the smell of smoky rooms – it seems to be unacceptable to expect smokers to refrain from smoking while eating or drinking.

[a] The English term 'bar' has a different meaning in German language, implying a place where one could consume expensive drinks in the evening or at night. Sometimes, the term 'bar' is translated wrongly, and contributes to the lack of understanding why anyone would wish to ban smoking in such a place. In Austria, one would call a 'bar' café (describing a coffee house or coffee shop, espresso, patisserie, tea house, etc.), or just sum up all premises for food and drink as *'Lokale'* (to be differentiated, however, from the local pubs!).

There is now an international consensus (with the obvious exception of the tobacco industry) that exposure to second-hand smoke is not only irritating for non-smokers but that it may also cause serious disease. Consequently, a concern to protect non-smokers from the health hazards of environmental tobacco smoke has led to smoking restrictions in public places. These have included restaurants, pubs and bars, both as workplaces for hospitality employees and places where non-smoking and smoking customers meet *(Chapter 4; APPENDIX G)*.

Bar workers, waitresses and waiters are known to be particularly vulnerable because they are exposed to tobacco smoke for many hours every day. As yet, however, this has been the subject of remarkably little concern in Austria. To date, this group is excluded from any protection by the Austrian Employees' Protection Act. Despite its recent amendment of 1 January 2002, the vague formulation of the law only stipulates that non-smokers can only be protected "as far as possible". The hospitality industry, the public and many hospitality workers themselves regard this problem as a kind of inevitable 'occupational risk'. Particularly crass, of course, is the situation with pregnant women in the hospitality business. Although this issue has been used as the strongest argument for a more restrictive law, it did not result in the inclusion of hospitality workers in the act *(Chapter 8; APPENDIX M)*.[281]

The issue of passive smoking is not, however, unknown in Austria, although it has been continually treated as something new for decades, stimulating astonishment and doubt whenever the issue was brought up. Anti-smoking activists have been pointing to this issue since the 1970s, demanding separated smoke-free environments in public places, including restaurants and bars. In 1988, the Austrian Health Minister Franz Löschnak, still not convinced by reports from other countries (including the Surgeon General's report), called a meeting of experts to discuss this subject. The meeting was financed and participated by the Austrian tobacco company, who kindly suggested inviting certain experts from overseas. Not surprisingly, the meeting concluded that there was no evidence of a relationship between passive smoking and harm to health, and nothing changed *(APPENDIX S)*.[342] Passive smoking was not again mentioned until 1992, when Health Minister Michael Ausserwinkler raised the issue of smoke-free environments in restaurants and bars for the first time. This was followed by "massive reactions", as reported by the former minister:

> *"Barkeepers and restaurant owners were told I would send out a troop of sheriffs to inspect abidance. Of course, this was ridiculous, but enough to upset them. It was difficult to keep up this front."* [277]

Even his citing of a European survey demonstrating overwhelming approval for smoking restrictions[405], by pointing in particular to the results from those countries which were interesting to Austria from the viewpoint of tourism (Belgium, The Netherlands, Germany, France), could not change the political climate and the industry-influenced and economy-oriented hospitality industry.

> *"This survey was conducted by the EU in 1993 with the result that about 75 percent of the respondents would not mind at all smoking restrictions in restaurants and bars while on holiday in Austria. Even among smokers the share of supporters was 50 percent. I presented these results to the Austrian tourism association, but it had no effects on them. It was too late, the opinion was already too solidified."*[277]

Only recently, with the announcement of planned EU activities to restrict smoking in public places and the introduction of the Irish smoking ban in March 2004, this threatens to emerge as a political issue, though not yet a matter of public concern. For most Austrians, even if they are non-smokers themselves and feel bothered by a smoky environment, it seems unimaginable that smoking should be banned from restaurants, pubs and bars. As Austria will most certainly be

one of the last countries that will comply with this guideline, it does not seem necessary for politicians to arouse the public ahead of time from its 'blissful tolerant sleep'.

As continually expressed by both the hospitality industry and the Health Ministry, the protection of customers from the hazards of tobacco smoke should be a 'voluntary' decision by every owner of a restaurant, pub or bar. However, as hardly any customer is explicitly asking for a non-smoking section, as such areas rarely exist, restaurant owners do not see the necessity of providing non-smoking rooms (not to mention the transformation of the premise into a non-smoking restaurant or café). As well as not recognising any demand, they have been assured for decades that this 'anti-social' measure would ruin business. In addition, as expressed in a meeting with Reinhart Waneck, Austria's State Secretary of Health, Austrian health policy favours the industry-friendly approach of suggesting non-smoking areas only in premises of a certain size.[288] Alongside with an absence of laws to protect non-smokers, there are also no recommendations on non-smoking areas on the part of the Hospitality Association.

In summary, therefore, Austria does not have a clean indoor air law, nor is there any intention to have one in the near future.[b] There are hardly any non-smoking restaurants, cafés or other establishments, not even in bigger towns or cities like Vienna where the exception from this Austrian norm are the 44 McDonalds restaurants, which offer either a complete non-smoking environment or at least declare non-smoking to be the norm[556], and the recently launched (currently 7 as of March 2004) Starbucks cafés. Ironically, both American chains are usually packed and there is no resentment about what has been described by others as a 'hysterical', 'intolerant' and 'totalitarian' American anti-smoking policy *(Chapter 9)*. Apart from these popular and economically very successful examples of American eating and drinking (and non-smoking) culture, in all of Vienna there are only 5 non-smoking restaurants (most of them offering organic, vegetarian, vegan, or macrobiotic food), 5 ice cream parlours, 1 internet café, 1 university canteen (with a separate room for smokers), and 13 mostly organic groceries or bakeries which occasionally offer snacks that can be eaten on the premises, which were non-smoking in March 2004.[557] [c] However, following media coverage of the Irish smoking ban, a newly developed internet page[558] includes information about non-smoking establishments.

In an internet information site on "Vienna warning or dangers tips", written by locals and travellers for Vienna, one can read a warning from a young Austrian woman:

> "If you mind smokers – be warned. Austrians are quite fond of smoking. You most likely won't make any friends complaining about too much smoking in Austria. Even though I smoke some of the bars in Vienna are so smoky that I cannot even stand it in there. Very few restaurants have a smoking or non-smoking section." [Original citation][559]

Austria thus distinguishes itself in its 'smoker-friendly' environment and the so-called 'tolerance' of non-smokers towards smokers. Even in September 2003, the State Secretary of Health, Reinhart Waneck, well aware of this smoker-friendly environment and the difficulties of health policies in reducing smoking in Austria,[560] announced that he is strictly opposed to smoke-free environments in restaurants, pubs and bars. Agreeing that nicotine addiction may be classified

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[b] The World Tobacco File 1998 reported that in the past (1997?) Vienna was considering a proposal to ban smoking in specially designated areas throughout the city while Graz had drawn up a proposal to ban smoking in restaurants, beer halls, cafés and other public places. At that time, so the report, the proposal to ban smoking in Graz could have become the strongest anti-smoking law in Europe. However, both statements could not be confirmed. There were no proposals of any kind to ban smoking either in Vienna or in Graz.[554] [555]

[c] However, some of these no-smoking premises do offer areas/rooms for smokers as well (particularly when a garden is attached). Surprisingly, not all restaurants serving organic and healthy food do ban smoking. One of those, visited particularly by females and young mothers with children, even displays the item "Smoking Articles" with 8 or 10 cigarette brands in its menu.

as a disease, he is afraid that a smoking ban would "criminalise" smokers. Instead, he planned to spend part of the tobacco taxes on an expanded prevention programme based on voluntary health examinations *(Chapter 8; APPENDIX T)*.[159] An ironical commentary in the newspaper *Kurier* concludes with the speculation that continued smoking in restaurants, pubs and bars would obviously be in the State Secretary's interest, ensuring high tax incomes from continuing high tobacco consumption and therefore ensuring enough money for the expensive screening programme.[290]

Although many Austrians now enjoy the benefits of a smoke-free environment in their work-place, or the amenities of a non-smoking flight, which would not have been thinkable, say, ten years ago, and while public opinion has not been assessed formally, many Austrians still feel that it would be presumptuous to demand a law on clean indoor air. Listening to the statements of Austrians about smoke-free environments in restaurants and bars one clearly notices the result of a most effective, decade-long lobbying of the tobacco industry and the use of industry-derived arguments. Smokers still claim their 'right' of 'freedom' and 'personal choice' (any attempts to restrict smoking are countered with "we are not in America"); politicians are afraid of becoming unpopular, loosing tax revenues or the benevolence of influential groups; owners of restaurants and cafés are afraid of losing customers (obviously ignorant of the evidence from other countries that business has rather gone up than down after the introduction of smoking bans); everyone seems to be convinced that all these problems could be dealt with by 'good ventilation' (ignoring evidence that 'good ventilation' that could eliminate harmful substances would have to have the force of a tornado); and, finally, that this is actually no real problem at all, at best a problem for some hypersensitive and militant non-smokers. Non-smokers themselves might complain but have no other choice – apart from staying at home.

Besides, smoking is often related to the ambiance of 'good-living' (eating and drinking) where 'a good cigarette is enjoyed after a good meal', thus equating cigarette smoking before, during and after meal (no matter if it is really a 'good' meal or not, or just a snack or a coffee) with the smoking culture in the smoking room of a gentleman's or High Society's club from the past. One is very quick in relating this benevolently to the Austrian *'Genusskultur'*, best translated with *joie de vivre* or 'culture of good living'. An often used argument is that, for a smoker, a cigarette after a good meal is no different from a cognac for a non-smoker (as yet, however, probably nobody has felt harassed by someone enjoying his post-meal cognac). It is all a question of "mutual tolerance". With a view to the designation of smoking/no-smoking zones, the restaurant guide *Gault Millaut* initiated the slogan "Tolerance Unites". In the following section, two examples of the role of restaurant guides in the consolidation of the close relationship between smoking and 'good living' are given.

As public awareness of the risks of passive smoking is low, those favouring smoking restrictions are not organised, no non-smokers' rights group is pushing for a change in attitude, and politicians are not interested in putting more effort into protecting non-smokers, there is presently not much prospect of change in sight.

Excursus: Smoking, 'good living' and restaurant guides

Joint venture campaign of Gault Millau & Austria Tabak "Tolerance unites"

A reportedly successful joint venture campaign of the restaurant and hotel guide *Gault Millau* and the Austrian tobacco company *Austria Tabak* called *'Toleranz verbindet'* (tolerance unites) should contribute to the promotion of tolerance between non-smokers and smokers in the catering business and promote the culture of 'good living' – including, of course, the post-meal cigarette.

The initiative was taken in about 1997/1998[561] by the editor of *Gault Millau,* Michael Reinartz, who presented his idea to the former General Director of *Austria Tabak*, Heinz Schiendl, who in turn found it excellent and supported it.[562] The aim was to promote ventilation systems and to identify smoking/no-smoking zones. Between a range of other symbols as to the availability of telephone or TV in the rooms, seminar rooms, sauna, tennis place, convenience for handicapped people, etc., a special symbol declaring "Smokers/Non-Smokers Zone/Rooms" is displayed in the guide for Austria.

> "If this applies also for other countries, I could not say. Anyway, in many countries this has become unnecessary, as smoking is not allowed in a restaurant."[561]

The 'Golden Cigar' of Austria Tabak and Falstaff Magazine

Different from the world of cigarettes, the world of cigars is small but exclusive and highly supported by Austria's tobacco manufacturers. Cigars are even more – and certainly more deservedly than cigarettes – related to the culture of good living. On 5 December 2001, the famous *Hotel Sacher* in Vienna was awarded with the "Golden Cigar" by *Austria Tabak*, represented by its General Director Heinz Schiendl, and the international magazine for eating, drinking and travelling *Falstaff*, represented by the two editors Helmut Romé and Hans Dibold.

This award is given for 'special cultivation of cigar culture, creativity in cuisine and choice of wine'. Until then, 14 Austrian restaurants were awarded this way. In the case of the Hotel Sacher it was, of course, also referred to Anna Sacher, who was not only extremely self-confident, but at the end of the 19th century adopted the then male domain by smoking cigars. Since then, Anna Sacher and her cigar have become the trade mark for the hotel. On the occasion of the 125 year jubilee of this traditional establishment on 10 December 2001, *Austria Tabak,* by mutual consent with the management of the hotel, brought an "Anna Sacher-Cigar" on the market.[563]

Picture 6 *Hospitality industry & tobacco industry. A happy and successful couple.*

The "Anna Sacher Cigar" was launched at the occasion of the 125 year jubilee of the Hotel Sacher

APPENDIX R

Tobacco policies in Germany and Austria in the 1930s and 1940s

Prior to describing Austria's tobacco policies over the last three decades, an excursion into the situation in Germany and Austria in the pre- and post-war period and the proposed (misleading) explanations is first necessary.

Germany

As with public health in general, German anti-smoking policies in the 1930s have been used as 'historical' arguments to express why today so little has been achieved in Germany with regard to tobacco control. Davey-Smith, Ströbele & Egger have even equated past anti-smoking campaigns with protofascist, totalitarian and authoritarian Nazi measures[564], heavily criticising Brenner for merely suggesting that "major public health efforts" would be "badly needed" in Germany "to limit the epidemic of smoking attributable diseases" in the latter's 1993 paper.[565 a]

Instead of reproaching the German government for its reluctance in efforts to tackle the smoking epidemic, as done by Brenner, Davey-Smith and colleagues reason that the failure of past campaigns and Germany's present reluctance in implementing anti-smoking measures, together with the poor response of Germans to any kind of anti-smoking efforts, should better be explained by Germany's "historical trauma". They argue that, "understandably", Germans would have a deep averseness to any kind of anti-smoking measures and, moreover, the experience of these restrictive measures during the Nazi period and the equation of Hitler being a non-smoker would lead to higher rates of smoking than in neighbouring countries.

Although it is true that in Germany and Austria one is very careful with statements and opinions concerning policy measures in this historical period, not wishing to be categorised as a Nazi-sympathiser, this explanation is implausible or even absurd. It rather reflects a well-known stereotype used by those for whom 'German' and 'Nazi' have become synonymous. However, one cannot interpret everything what is done (or not done) in Germany by reference to its 'traumatic historical past'. It would rather seem that the argument of Davey-Smith and colleagues is used as an excuse for the stubborn resistance of a public which, like in Austria, had been successfully influenced and opinionated by industry arguments and whose government and media have been close allies to the tobacco industry for decades. Although Germany had a very powerful anti-tobacco movement in the past, Germany (and Austria) have never experienced the prohibition of alcohol and tobacco like the United States which, following the arguments of Davey-Smith *et al.*, would have given more reason to oppose any kind of regulations. Indeed, the United States has been among the forerunners in smoking bans.

In addition, it implies – more or less directly – that all kinds of anti-smoking policies would be 'totalitarian', 'authoritarian', or 'protofascist', picturing post-war Germans as a population of

[a] Brenner's proposed measures included comprehensive school health education programmes, supported by appropriate advertising restrictions and media campaigns; smoking control programmes at the workplace, including smoking cessation classes, self-help materials and one to one counselling; and restrictive smoking policies to be implemented at the workplace, in public buildings and in transportation system, as a measure to protect non-smokers against passive smoking and help active smokers to quit.[565]

active anti-fascists who "deliberately resist health promotion" to show their "opposition to an authoritarian government"[564] – a kind of over-reaction to Hitler being a non-smoker.

In the same way, the high meat consumption after the war would have to be interpreted as a reaction to Hitler being a vegetarian, the dominance of a coffee-culture in Germany as a reaction of Hitler preferring tea, and the high alcohol consumption a reaction to Hitler being a teetotaller (the latter argument was made by Gumpert as early as 1940[566]).[b]

Instead, the disproportional post-war increase in food, alcohol and tobacco consumption in West Germany, and later the enormous demand for luxury goods, were rather a reaction to the previously imposed privations, combined with a very fast economic recovery.[567]

Grunberger, an Austrian Jew who escaped in the *kindertransport* to England and thus survived, describes how an economic upturn and intensified attitude towards life can lead to an "increased weakness" for drinking, smoking and entertainments.[568] As reported by Grunberger, cigarette and cigar consumption doubled in the Reich between 1932 and 1938. The war actually accelerated this trend, despite the increased taxation on tobacco products.[568] During the war, soldiers at the front were given tobacco rations, those engaged in military service were partly paid with cigarettes, and women, who worked under most stressful conditions, making nervous and physical exhaustion, fatigue and mental stress a common phenomenon, smoked increasingly.[568] This reopened controversies about female smoking (infertility, stillbirth, miscarriage, etc.). In the post-war period, tobacco also adopted the role of a substitute currency.[568]

Similarly, Robert Proctor reports that tobacco consumption grew dramatically during the first six or seven years of Nazi rule (i.e. between 1933 and 1939), "a consequence of the post-1933 economic boom".[117] Apart from this economic boom, massive campaigns by the tobacco industry encouraged increased tobacco consumption – despite the powerful activities of anti-smoking groups.[c] In addition, tobacco has always provided an important source of revenue for the national treasury, then and now. By 1941, tobacco taxes "constituted about a twelfth (!) of the government's entire income. Hundreds of thousands of Germans were said to owe their livelihood, directly or indirectly, to tobacco".[117] Ernst Röhm's *Sturmabteilung* (storm troopers, SA) had begun to manufacture its own brand of cigarette (*Sturm* cigarettes, manufactured by Trommler in Dresden) to raise much-needed cash.[117] German tobacco consumption did not begin to decline until 1942, when consumption peaked at 80bn cigarettes. At that time, wartime restrictions brought tobacco rationing and bombing raids began to reduce stores of cigarettes (e.g. Cologne). Reduced availability, direct efforts to reduce tobacco use among soldiers, and new wartime taxes made the habit somewhat less affordable. While more people had started to smoke, the total consumption of tobacco had decreased, as reported in a 1944 survey.[117] Post-war poverty further cut consumption, whereby the decline was quite dramatic, dropping by half

[b] Besides, it is well known that Hitler's own 'health fascism' and hypochondria were rooted in his syphilis infection. With a "healthy lifestyle" he tried to prevent paralysis. Before being infected, he was a heavy smoker (smoking 25-40 cigarettes per day[117]). Besides, nobody ever related the high smoking rates in Italy and Spain to Mussolini and Franco, both being non-smokers too.

[c] "The economic recovery in the first six years of Nazi rule boosted the average German's purchasing power, and tobacco companies took advantage of the boom to promote their products. German antitobacco activists were aware of this and frequently complained that their own efforts were no match for the powerful 'American-style' ad campaigns waged by the industry".[117]

from 1940 to 1950.[d] Many Germans and Austrians grew their own tobacco in their gardens for home use or trade, a practice, which was actually promoted in a 1944 booklet by the Reich Institute for Tobacco Research in Forchheim, and continued after the war. In Germany, post-war tobacco rations were only about a fifth of the early wartime rations and even after the war, women received only half rations[117] *(for more on the situation in Austria see later).*

Similarly, the reason for the failure of youth anti-smoking measures is more complex than the postulated "resistance to authoritarian measures". Admittedly, smoking was associated with jazz, swing dancing and rebellion, and smoking by members of opposition youth groups may therefore have been a means to demonstrate their resistance. A more important factor, however, in the high smoking rates among youths[e] was the social conditions that existed during war time, such as the neglect of children and youths (mothers had to work 10 or 12 or more hours a day, fathers were on the front or in military service)[567] and the high smoking prevalence among male adults.

That the various smoking restrictions in Germany were not an overwhelming success at that time is therefore neither surprising; nor can it be interpreted as a result of a nation-wide protest against the regime. As indicated, economic recovery in the 1930s and later the stressful social conditions during war time, played a crucial role in determining the smoking behaviour of the population.

The argumentation proposed by Davey-Smith and colleagues is also misleading as only very few of these anti-smoking regulations were uniform to the whole Reich. Very often they were only local or regional regulations, adopted by overzealous party members, which, due to their being so extreme, became 'famous' and synonymous with the Reich's policy. Examples for such local excesses are the prohibition of public smoking by boys and girls in the German Land Mecklenburg, on pain of penalties of two weeks prison or a fine of 150 Reichsmark (even reported in the Daily Telegraph of 1 June 1936), or the instruction of members of the police force in the German town of Erfurt to remind women smoking in public of their duties as German women and mothers, or the public contempt and even verbal abuse of women in Berlin who wore make-up (or just powder and lipstick).[568] [f] However, as was reported in the case of women wearing make-up, this does not necessarily mean that these regulations were approved at the 'top', often remaining a local affair.[568] In addition, these examples show the inconsistency and variation even within Nazi Germany. (Violations of the Reich-wide smoking ban in trains, for example, were rarely sanctioned.[117]) In Austria, these anti-smoking-regulations did not exist, even in Vienna.[567]

With regard to youths, it was only on 9 March 1940 that a comprehensive youth protection law was issued for the whole Reich, prohibiting smoking under the age of 18 years and prohibiting the serving of alcoholic spirits to youths under 16 years of age[568] – regulations that are not much different from today.

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[d] The German tobacco industry's inability to secure raw tobacco from other countries resulted in 'help from America': "Shortages remained so severe that American authorities decided to ship tobacco, free of charge, into Germany as part of the Marshall Plan. ... The net cost to the U.S. government was on the order of seventy million dollars; the benefit, at least for the American tobacco firms, was a gradual shift in German tobacco tastes from the traditionally favored black tobacco to the milder, blond-Virginia blend".[117]

[e] A study carried out on 200 14-year olds in Hanover in 1940 showed that 9 of 10 had already smoked and every 10th was a regular smoker.[568]

[f] Public disapproval of women wearing make-up during war-time or smoking publicly was also known from non-fascist England.

As in most other countries at that time, smoking in the streets was considered 'bad manners', particularly for women. In Austria, as in many other European countries, both before and long after the end of the war (especially in the rural areas), women who smoked in the streets were categorised as 'loose women' or even whores.[569] Naturally, rules of good manners were to be followed more strictly by those who should set a 'good example', such as teachers or members of the military force (although this was not interpreted as strictly in Austria). For youths, who were (at least officially) not allowed to smoke, the ban on public smoking was self-evident. The 1939 ban by Göring (himself a heavy smoker who continued to smoke in public[117]) on smoking in the streets, in particular for members of the military force[564], must therefore also be seen under this perspective rather than being part of a "vigorous fascist" anti-smoking policy.

That women and girls were much more strongly dissuaded from smoking than were men and boys, as they were more sensitive and vulnerable to tobacco smoke, might have been rooted in the presumption of the "sanctity and delicacy of the female body" and its importance in bearing and caring for children.[117] However, apart from the ideological background, the main message (including the higher risks for miscarriage, stillbirth, etc.) is the same in the 2001 U.S. Surgeon General's Report on Women and Smoking.[206] Similarly, an Austrian 1997 survey reported that women feel more often harassed by tobacco smoke than men.[11]

Equating calls for anti-smoking measures in Germany with sympathy for Nazi measures or an "understandable desire to forget history", as argued by Davey-Smith and colleagues[327], is therefore not justifiable. In addition, whatever the motives at that time might have been, the evaluation of tobacco control measures should not primarily be based on the political background. The "vigorous" implementation and "energetic" anti-smoking campaigns by Nazi Germany, encompassing an age limit of 18 years for smoking in public, advertising restrictions, and smoking bans in public places, including some workplaces, government offices, transport systems, schools, hospitals, etc., due to the dangers of "passive smoking" (a term already coined by Fritz Lickint in 1939), are more or less in accordance with 'modern' measures successfully implemented in several other countries (excluding, of course, the above mentioned extreme sanctions imposed by some local or regional administrators). The main reason for these smoking bans was not always a concern for health; some were primarily designed to prevent fires. However, health was clearly the predominant concern in advertising restrictions.[117]

The 'false' motives should therefore not necessarily devaluate the measures themselves. At the time, Germany was far ahead of all other countries, both with respect to epidemiological studies on smoking-related diseases (years before the take over by the Nazis *[Chapter 7]* and with not all later researchers being driven by party ideology even if it was advisable to become, officially, a party member), anti-tobacco organisations (since 1904) and anti-smoking measures, involving extensive public health education, bans on certain forms of advertising, and restrictions on smoking in many public spaces.[117] More than 60 years before the World Bank's publication, tobacco use was attacked as "epidemic". Today, nobody would describe similar measures in California or elsewhere with terms such as "aggressive steps", "government propaganda", "fascistic", etc. In Austria, disapproval of these measures in other countries is mainly expressed using terms like "hysterical", "exaggerated" and "puritanical".

As to motives for campaigning against smoking, neither in the 1930s and 1940s nor today has the main motive been a concern for individual or population health. While German Nazis wanted the population to be healthy and fit for work and war ("duty to be healthy"), and sufficiently numerous to colonise the new countries in Eastern Europe, as well as realising the dangers of financial drains on the health insurance system,[117] our concerns today (even if the ultimate goals differ) are not so different, although perhaps more acutely directed at the rising cost in health care and (even though not yet outspoken in Austria) in the loss of workforce and sub-

sequently loss of income for the already stretched social insurance system. Then and now, motives are driven rather by political or economic than medical or social interests, despite using arguments such as loss of years of life and risk of diseases for the individual. In addition, the state's budget and economy was and is highly dependent on incomes from the tobacco trade, thus constraining effective policy.

Consequently, a certain inconsistency between intentions and reality may be observed, both in past and present German and Austrian tobacco policies. For example, notwithstanding the restrictive measures in Nazi-Germany, no one seemed concerned about the respiratory health or the 'un-German' behaviour of soldiers in the field to whom tobacco and alcohol were distributed.[g] Or the illogicality of prohibiting smoking for youths while paying 17 year old reporters of air-raid damages *(Meldegänger)* or equally young assistants of anti-aircraft artillery *(Flakhelfer)* partly in cigarettes.[568] The hypocrisy of today's smoking policies can be seen in the avowed concern about the health of youth while opposing the removal of cigarette vending machines or the implementation of smoking bans in schools. *(Chapter 9)*.

Austria

As noted earlier, the situation in Austria in the 1930s and 1940s was somewhat different from that in Germany. Austria only joined the Reich in 1938[h] when the war was about to start. In the beginning, the newly established Nazi regime in Austria had more immediate problems than being concerned about the people's health or behaviour. It had to convince the population of the benefits of the new system and the recovery from what had been a very bad economic situation until then. The regime was also preoccupied with establishing a new administrative system in Austria which, unlike Germany, had a very rural structure. From when National Socialism came to power in Austria in March 1938 until the start of the Second World War on 1 September 1939, the new rulers in Austria were preoccupied with the consolidation of their leadership by introduction of regulations already in force in the *Altreich* (Germany), terror, and looting national resources of the *Land Österreich*[i] (Austria). These measures seemed much more important to the Nazis than campaigning against smoking or the consumption of alcohol.[567]

While, of course, it was not popular to smoke as a member of a sports or gymnastic association (which were often but not always related to party ideology), there has never been social ostracism because of smoking in Austria, nor have there been any anti-smoking groups. Age limits

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[g] There was some medical evidence, though, that smoking impaired a soldier's marksmanship and reduced his ability to march for long distances, and increased the risk of heart attack, and Hitler seemed to have regretted in 1942 having allowed his soldiers to smoke. However, after complaints about the inadequacy of tobacco rations in 1943, the previously reduced tobacco yields were again increased in the spring of 1944 to 1941 levels, mainly to satisfy military demands.[117]

[h] The accession of Austria to the Reich took place on 12-13 March 1938; before that, the National Socialist German Workers' Party (NSDAP) and the Hitler Youth were illegal.

[i] With the incorporation of the until then autonomous *State Österreich* Austria had become the *Land Österreich*, i.e. one of the Länder of the Reich. Occasionally this territory was also called *Ostmark* by the new rulers, although it expanded into law only in 1939 with the so-called *Ostmarkgesetz* (Ostmark Act) of 14 April 1939 (RGBl. I, p.777), which divided the uniform area into independent *Reichsgaue*, sometimes also summarised as *Reichsgaue of the Ostmark*. However, to erase any memory of Austria, even the term *Ostmark* was annihilated from the vocabulary of the rulers; from 1 April 1940 onwards the 7 *Reichsgaue* in the Austrian territory were summarised as the *Alpen- und Donaureichsgaue*, including Vienna, Lower Austria, Upper Austria, Salzburg, Vorarlberg and Tyrol, Carinthia, and Styria.[567]

for smoking were not imposed by the Nazis; at that time, smoking was generally forbidden to individuals younger than 18 years.

Nazi propaganda in Austrian youth associations did not include the issue of smoking as a health concern but rather, if at all, as being something 'un-German'. Therefore, apart from complying with the age limit, Hitler youths were not supposed to smoke, but it was the members of the core Hitler youth association *Stamm Hitler Jugend* who were more strict (at least officially) than the later forcefully integrated youth groups (such as the Catholic Youth, etc.). In the rural areas, however, even the core youth association was very relaxed about smoking as a particularly 'un-German' behaviour.[569] According to contemporary witnesses, "everybody" who could afford it smoked. At that time, the only threat to minors was a rebuke by adults when caught smoking.

In Vienna, youngsters from the working class who did not want to join the Hitler Youth were called *'Schlurf'*, describing an 'untidy' person, wearing dandified instead of soldierly clothing, usually pictured with 'long' hair (i.e. touching the collar of the shirt), a rakish cap, and a fag hanging out from the corner of the mouth[570] – the embodiment of someone that a 'good' boy (or girl) or upright citizen would not wish to socialise with. In contrast to the Hamburg Swing Youth or the Edelweiss Pirates, though, the Austrian *'Schlurfs'* were not organised, i.e. there was no equivalent of an organised opposition group to Nazi youths in Austria. From 1940 onwards[j], joining the Hitler Youth was obligatory, like military service.[567]

Before 1938, the economic situation for most of the working population of Austria was so bad that few of those who could afford tobacco (or made some kind of cigarettes from other plants) were concerned about health effects. During the war, cigarettes (or tobacco and cigarette paper) were distributed to soldiers in the field (as well as alcohol, in particular prior to military action). This led to the high smoking rates in these birth cohorts which can be seen still today.[k]

Restriction of distribution of tobacco products was only ordered by the Reich Economy Minister on 7 January 1942.[571] According to this ordinance, tobacco products were rationed with the issue of coupons. Infringements were sanctioned severely.[l] It is noteworthy that, especially at that time, the Reich Propaganda Office pointed to the purpose and the uncommon rigour of these sanctions: "With the continuing of the war the control of consumption of industrial goods is gaining in importance: As is generally known, this should serve to secure the fair share of vitally important *[sic]* goods to all comrades *[Volksgenossen]*..."[572]

Beside this announcement of the Reich Propaganda Office, the new *Raucherkontrollkarte* (smokers' control coupon) was pictured. Originally, these coupons should come into effect from 15 February onwards, but had to be postponed to 1 March 1942. Those entitled to benefit were men from 18 years and women from 25 years onwards, whereby women were only eligible to half of the rations granted to men. Not all persons, though, were eligible for coupons;

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j The respective act was of 25 March 1939, coming into force on 7 April 1939. However, the actual enforcement was somewhat later.

k While those who had to join the army in their young years continued to have high smoking rates after the war, the birth cohort that reached the crucial age of 16 to 18 in the post-war years shows the highest proportion of never-smokers *(Chapter 6)*.

l Sanctions for infringements were separated by type: infringements in the retail sale or infringements in tobacco cultivation.

most Jews, for example, were excluded.[m] At first, these coupons for tobacco were distributed to all eligible persons in the respective age groups, regardless if they were smokers or not, if the necessary application was made. But already in the same year, following complaints from smokers about non-smokers receiving the same rations as smokers, women aged 55 years and over were basically excluded if they could not prove that they were smokers.[573] However, women under 25 years of age (regardless of smoking status) and over 55 years of age (even when non-smokers) could get tobacco coupons when it was in the "interest of the bonding between front and home", i.e. when their husband or unmarried son was in service at the front. The relevant note also refers to the reason for this restriction and, while dismissing any hope for a subsequent increase of the rations for smokers, emphasises that, in view of the "more and more emerging scarce situation in raw tobacco" one may not reckon with an increase of the allocation.[573] In cases when individuals were "clearly identifiable as non-smokers" tobacco coupons could be cancelled.[574] Members of the Wehrmacht, the SS, the *Reichsarbeitsdienst* (RAD, German National Labour Service) and the Organisation Todt did not receive tobacco coupons but were provided directly by their organisations with a comparatively generous ration of 4 to 8 cigarettes per day.

These restrictions thus were purely based on war-related economic reasons, as tobacco was one of the products that had mostly to be imported and used agricultural lands in Germany that were badly needed for staple foods.[n] Austria also had its own tobacco producing regions (southern Styria and also Lower Austria) and, as in Germany, many people had grown tobacco plants in their own gardens. However, as with food, tobacco was regarded as something 'vitally important' and had to be delivered to the local administration.[567]

An interesting Austrian peculiarity is the fact that the establishment of the daily quantities of tobacco per coupon was based on an agreement between the regional economic office *(Landeswirtschaftsamt)* and the Austrian tobacco company, then *Austria Tabakwerke-AG*.[575] In the economic district 17, comprising Vienna, Lower and Upper Austria, the daily rations in 1942 were 3 cigarettes (for men), i.e. per month 90 cigarettes for men and 45 cigarettes for women. For one packet of cigarette tobacco (50g), 14 coupons were necessary; for 1 packet of pipe tobacco, 7 coupons.

As noted earlier, the entire tobacco business was a state monopoly in Austria. In April 1939, the company was turned into a stock corporation *(Austria Tabakwerke AG)*, with 100% of the stocks owned by the state.[o] Although formally subordinated to the Finance Ministry, the company exerted great influence on this Ministry. Remarkably, relics of this exceptional position remained during the Nazi-era. While, for example, in the whole Reich the official regulations on the distribution of tobacco products were controlled by regional economic offices, the surveillance in the so-called *Alpen- und Donaureichsgaue* (Austria) was performed by organs of the Reich Finance Administration in co-operation with the Austrian tobacco company.[576]

Immediately after the onset of the Nazi period, Jewish tobacconists were dismissed and 'victims' of the 1934 July coup (then illegal Nazis) as well as Nazis who had formerly owned tobacconist shops but were victims of the anti-NS-measures of the Austrian government before

[m] The application for tobacco coupons required the presentation of the *Reichskleiderkarte* (coupon for clothes), which was generally not granted to Jews and other 'undeserving' groups unless they had working status. Then, however, they were only eligible for working clothes and not for other clothes and additional benefits, such as tobacco.[567]

[n] Nevertheless, mainly to satisfy military demand, German tobacco fields were again increased in the spring of 1944 to 1941 level *(see Footnote g above)*, showing the priority over staple foods.

[o] This has held until 1997 before the beginning of privatisation of the company *(Chapter 3)*.

1938 were again appointed.[p] Obviously, nobody was concerned about any 'un-German' behaviour of these Nazi tobacconists.

During war time, there was no kind of anti-smoking policy in Austria, apart from the official age limits. Smoking was common, particularly, though not only, among the male population, and non-smoking among men was rather an issue of affordability than anything else.[569] After the war, no specific anti-smoking policies were needed either as most people, especially the young, could not afford to buy cigarettes or tobacco anyway[q] and concerns were directed at more immediate threats. During the years of allied occupation (1945 to 1955), contraband trade and black market sales were common sources of cigarettes, particularly in the zones occupied by American or British troops. Cigarettes were bought illegally from soldiers (mostly by young Austrian men) and re-sold on the black market at much higher prices. Foreign cigarettes were also used as currency. Both English and, in particular, American cigarettes were highly appreciated for their better quality and the more appealing package design, giving smoking a touch of glamour and luxury[r] compared to the Austrian home brand A3. Of course, if caught, it meant being imprisoned, but this applied to all black market activities.[569]

Only in the period of economic recovery, especially after the withdrawal of foreign troops in 1955, a new lifestyle emerged, largely influenced by American movies and later television. Smoking then was synonymous with freedom and luxury. In the 1970s, virtually everyone (men and women) smoked in movies and television series, including Austrian productions. While smoking first became more and more popular in the male population after the mid 1950s, women increasingly started to smoke in the 1970s *(Chapter 6)*.

In conclusion one can say that, although there might have been some 'health obsessed' Nazi party members who believed very strongly in a non-smoking ideology, smoking has never been a primarily political or public health concern, whether for the Nazi regime or any other political group in Austria, nor has it ever been a concern for the Austrian population (apart from the social disapproval of female smoking). Much more popular concern, for example, surrounded the closure of Vienna's *Heurige* (wine taverns selling new wine) by the Reich Governor *(Reichsstatthalter)* Arthur Seyß-Inquart in 1939. The ostensible argument was that during war time one should not entertain oneself in this way. A more immediate reason, of course, was the fact that the winegrowers could be made to deliver more wine to the administration to be redistributed.[567]

It is not that all regulations and opinions of the Nazi ideology were taken over as reluctantly as regulations on smoking or drinking. In the case of anti-Semitic laws, for example, Austria was known to be very obedient, on the local or regional level sometimes even before being asked

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[p] On 17 March 1938, a decree of the Federal Ministry of Finance to the presidents of all financial district offices required that Nazis who had lost their tobacconist shop during the Dollfuß era (i.e. since the end of 1933) had to be reemployed. Item 11 decreed that all tobacconist shops owned by Jews had to be reported by name.[577] The second step was the displacement of Jewish tobacconists of the personal conduct of business and their replacement of Nazis. In reality, this meant already a disfranchisement and an expropriation of Jews. As one could read in a weekly local newspaper in May 1938: "Last week, in the course of the cleansing of Jews *[Entjudung]*, all tobacconist shops owned by Jews were handed over to Arian operators."[578]

In August 1938, a law was in preparation (initiated by the Reichsstatthalter Seyß-Inquart) requiring that Jews should lose their licence and drop out of the state tobacco retail monopoly, independent of being war victims or former front combatants.[579] However, due to the soon following pogrom which resulted in a general exclusion of Jews from all business activities in the whole of the *Reich*, there was no more need for the enactment of this law.[567]

[q] At least, not in big quantities. Besides, smoking coupons still existed for some time after the end of the war.

[r] Popular American brands were, for example, Lucky Strike, Camel, Pall Mall, Chesterfield; the most popular English brand was Navy Cut.

for. (Vienna, for example, was known to be particularly oppressive to Jews.) However, Austrians have been known to be a rather hedonistic type of people and they do not give up 'dear habits' easily, as already observed in a confidential report by Philip Morris in 1979[5]. Laws regarding alcohol consumption and smoking restrictions have therefore always been interpreted very laxly, by both legislators and public. Due to the mostly rural structure of Austria at the end of the 1930s, characterised by many settlements with scattered buildings and a few towns with only one large city (Vienna), a 'crack down' on smoking or drinking would have been very difficult anyway.

Tolerance towards smoking and drinking habits in Austria after 1945 has thus been driven by hedonistic rather than anti-fascist motives. Contemporary smoking behaviour also reflects effective promotion by the tobacco industry. As with Germany, behaviour such as challenges to EU legislation, deliberate misleading of the public on health hazards from active and passive smoking, refusal to enact effective tobacco control measures, and entertainment of friendly relationships with the tobacco industry, can hardly be explained as a 'tolerant ethos', a protest against fascism, or a reaction to the past. Having had the opportunity to hear the opinion of people from different countries on the subject of smoking bans in public places, the success of the industry's propaganda in the creation of a 'smoker-friendly' climate (even among members of the public health community) in countries such as Austria and Germany becomes particularly apparent. In the face of developments in other European countries, a fear of being categorised as a Nazi-sympathiser when pleading for smoking bans in public places cannot be considered a valid 'excuse'.

Nevertheless, these arguments, readily taken up by both government and public, have some relevance to Austria. The description of anti-smoking measures as being 'protofascist' and 'authoritarian' and recalling a traumatic past, has been adopted and disseminated by the Austrian media *(Section 9.3.8)* and used by industry-sponsored smokers' associations as the Austrian Club of Forces International, named "Association of Tolerance" *(see later)*:

> "It is a pity that history is repeating itself and mankind does not learn from its mistakes. About 5-6 decades ago a certain fanatic failed in Austria but was received with open arms in Germany and put the world into a world war."[335]

It has also become a popular position among those on the political left to demonstrate a tolerant ethos and reject anything that could possibly be related to Nazi ideology.

In any case, the cultivation of this artificial justification helps to impede an engaged tobacco control policy in Germany and Austria. The implied but unwarranted linkage of all kinds of tobacco control measures with authoritarian Nazi-methods are in the interest of the industry, which could not have found a better argument.

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[5] In this report, the public attitude in Austria is summarised as follows: "In general, the Austrian populace is aware of the claimed harmfulness of smoking. Nevertheless, the Austrians are individualists and are equally concerned with maintaining and enjoying their pleasures in life, one of which is smoking." [104]

APPENDIX S

Health Minister Franz Löschnak and the 1988 Vienna Passive Smoking Hearing

The antecedents of the hearing

It seems likely that a written parliamentary question by Günter Stummvoll (ÖVP) to the National Council of 5 May 1987 was the reason for the announcement of a "passive smoking hearing" in the summer of 1987. The altogether six questions inquired on the Health Minister's intentions to protect non-smokers, in particular banning smoking in public buildings (e.g. hospitals) and intentions concerning public awareness building and making available information about the risks of passive smoking public. A translated version was found in the Philip Morris archive.[338]

Already in 1987 Löschnak's statements on tobacco control seem to anticipate the findings of the hearing taking place one year later. Apart from his close relationship to *Austria Tabak*, it is not clear on whose expertise the Health Minister relied. It is possible that one of these experts was Michael Kunze, at that time already "the" national tobacco control expert and whose opinion on passive smoking and smoking bans in public buildings and workplaces is still the same today *(APPENDIX U)*. However, the answers given by Löschnak are not at all supportive to anti-smoking policies but rather the tobacco industry's point of view. His answers read as follows *[original translation; bolding by E.B.]*:

Question 1. Will you as the Minister for Health ensure that the people are made more aware of the harmful effects of smoking on health by means of systematic and comprehensive health information and education?

> "This question calls for systematic and comprehensive health information and education for the population on the harmful effects of smoking on health. In fact this task has already been fulfilled by my predecessors during 1981 and 1985 in the form of two large-scale anti-smoking campaigns. **However, the experience has shown, as in other countries, that such major campaigns may succeed in putting across information about the health risks of smoking, but are poorly suited to actually getting smokers to change their smoking behaviour.**
>
> "So in the future it would be preferable to adopt specific and systematic measures directed at particular target areas. Primary preventive measures should focus on children and young people. In this extremely difficult endeavour to change the behaviour of those who have already acquired the smoking **habit**, co-operation must be stepped up with the **established medical profession with a view to increasing the patient's personal motivation to stop smoking**. Other fields of health care, such as the **periods spent at health resorts**, should also offer the patients more help in giving up the smoking habit."[338]

Question 2. Will you as the Minister for Health ensure that information about the risks of passive smoking is also made public?

> "**The effects of passive smoking on adults are disputed among experts**. Different studies on this subject have come to different results. One criticism levelled at those studies which have established a harmful effect on health of passive smoking is, for

example, that **other environmentally-related factors, such as air and dust pollution, etc. are not, or not sufficiently, taken into account.**

"**Unintentional shared smoking – even if the risk to health is only presumed to exist – is still often an unpleasant nuisance imposed on the passive smoker. So smokers should be educated to show consideration.**"[338]

Question 3. Will you as the Minister for Health ensure that parents in particular are made aware that their smoking can harm their children?

"The hazard to health of 'passive smoking' has been proved beyond doubt for the foetus and infants. The relevant facts have therefore been included in the **leaflet** accompanying the 'Mother and Child Passport'.

Particularly important for the personal motivation of the parents is, furthermore, cooperation with the medical profession and health-related agencies such as the **parental and family advice services.**"[338]

Questions 4 and 5. Can you as the Minister for Health envisage that smoking may be banned in public buildings? – If so, in which buildings?

"**It is not clear from the question what is actually meant by 'public buildings'.** From the technical point of view, the experts in my department do at any rate consider it **appropriate that a ban on smoking be introduced in places with a limited supply of fresh air so as to protect the non-smokers.**

"In the office buildings of the Federal, Land and local authorities, as well as in other public bodies, etc. with office hours, a **smoking ban in waiting rooms and corridors** is in any case conceivable. I will approach the authorities responsible for the relevant regulations on this subject.

"**However, the imposition of bans always carries with it the question of supervision and possible sanctions if the ban is to be more than just a sop.**"[338]

Question 6. Could you, in practice, envisage proposing a ban on smoking in hospitals?

"It can be said in general that smoking in hospitals is already currently restricted to just a few places. As regards a blanket ban on smoking in hospitals, the **above-mentioned question of monitoring and possible sanctions is particularly relevant here.**

"Generally speaking – and this accords with the position of the World Health Organisation ('Promotion of a positive attitude to health') – adopting the line of **pointing out the advantages of not smoking as well as appealing to smokers to show consideration for non-smokers is, in the long run, likely to produce more results than bans. Bans should be used sparingly and only in cases which the smokers themselves can see are justifiable and which, for that very reason, they are prepared to abide by.**"[338]

Similarly, in an article in a German magazine the Austrian Health Minister is quoted with regard to advertising bans as follows:

"Experience from previous anti-smoking campaigns shows that (advertising) bans to not lead to significant results".[301]

In particular, since German magazines containing tobacco advertising would be distributed in Austria, the Health Minister argued that a total advertising ban in Austria would be quite ineffective. This article also referred to the "failure of traditional anti-smoking campaigns", urging the Health Ministry to target future campaigns at specific groups, "concentrating on objective information and promoting the positive image of the non-smoker".[301] However, public funds for

such campaigns would not be available, and so the Health Minister counted on physicians, schools and mothers' advice offices to warn about the claimed effects of smoking.[301]

The industry's involvement

Although it was denied by the Health Ministry at the time, *Austria Tabak* and the Europe office of Philip Morris organised (in co-operation with the health authorities) the symposium *"Krank durch Passivrauchen?"*. The hearing was announced to *Austria Tabak* almost one year earlier and already in September 1987 basic agreement on the subject-matter and the speakers was achieved. Proof of the involvement of the tobacco industry in this meeting can be found in a Philip Morris inter-office correspondence note:

> "The plans were announced in the summer and detailed provisional arrangements were worked out and were discussed with representatives of the Austrian authorities on September 29, 1987. Agreement in principle on the subject-matter, the people to be involved and the organizational outlines was achieved, and further discussions have resulted in more detailed management."[339]
>
> "The programme and speakers will be as suggested by ATW *[Austria Tabakwerke]*, with the addition of Prof. S. Tanneberger of the Academy of Sciences of the GDR who will speak on TO 5." [339]
>
> "Officially, the Austrian Federal Ministry of Health is responsible for the arrangements." [339]
>
> "Since the arrangements are officially being made by the ministry, it will send out all the invitations and will pay the resulting costs. In addition, the following costs will be borne by the ministry: accommodation for speakers, invitation to drinks in the evening, minute-taking and publication of the minutes, and the press conference. ATW will pay the costs of the travelling expenses of the speakers, costs at the meeting location and for technical equipment and catering. A rough calculation of the costs to ATW is 700,000 Austrian Schillings." [339]

As late as one day before the meeting, the industry was very busy with preparations, as noted in an industry report from Sunday 1st May 1988:

> "Meeting in Vienna with Dr. LACHNER (AT), Mr. DEMBACH and Dr. STUHL (RJR) and Mr. DOHMS (Brinkmann) in preparation for the Symposium (in fact a hearing) called by the Austrian Minister of Health entitled "Krank durch Passivrauchen?" (translation: Sick Through Passive Smoking?). Unfortunately, Dr. KLUS, who is the scientist in charge of organising the symposium on behalf of the Austrian Authorities, was unable to attend this preparatory meeting. However, Dr. LACHNER mentioned that Drs. KLUS and ADLKOFER were busy with preparations for the meeting." [340]

This stands in contrast to the defence of a ministerial spokesman when answering criticisms of the running of this symposium. In the Austrian Medical Journal he wrote that "during the brief run of the symposium it had not been possible to go into the health hazards of smoking as such. Furthermore, although Austria Tabak had helped with financing the venue of the meeting, AT had not exercised any influence on the programme".[a580]

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[a] It is not clear if it is complacency or deliberate misleading when the report continues: "It was pointed out that while the symposium had shown no evidence that 'passive smoking' caused health risks, Minister Loeschnak had nevertheless taken numerous *(sic)* steps to protect non-smokers from the unpleasant effects of 'secondary smoking'."[580] Another report shows the complacency and the misleading message of the Austrian Health Minister: "Loeschnak pointed out that even with the limited resources available it had proved possible to change the Austrians' smoking habits so that during the past 25 years the proportion of filter-tipped cigarettes had risen from 15 to 98 percent."[581]

The industry not only proposed the speakers, it also decided (in agreement with the health authorities) that the meeting to be only one day.[339] It also planned a subsequent television discussion on the topic of passive smoking and was "involved" with the secretariat of the Health Ministry, as a note by Philip Morris officials from the day of the press conference (Tuesday 3rd May 1988) reveals:

> "The written information for the press, which was supposed to summarize what had been said during the Symposium, uses some very unfortunate formulations, in spite of the fact that both Drs. KLUS and ADLKOFER were involved with the secretariat." [340]

Participants and topics of the meeting

Participants in this hearing (the speakers were 21 scientists, mostly experts from Germany and the United States, but also a few from Austria) were throughout at least 'industry-friendly' and 'harmless'; many of them are meanwhile known to have been funded by or working for the industry for many years (as, for example, D. Hoffmann and E. Wynder[b] from the United States, or F. Adlkofer, K. Überla, K. Thurau, and G. Lehnert from Germany).[339] Some were even representatives of the tobacco industry (e.g. H. Klus from *Austria Tabak*). Professor Ernst Wynder, one of the most prestigious "under-cover" industry-funded scientists, played a key role in this symposium (summing up of the results on the side of the chairman and former health minister Kurt Steyrer and conducting the following press conference on the side of Health Minister Löschnak).

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[b] Even in 1999, Ernst Wynder (born in Germany, emigrated to the United States in 1938, returned to Germany at the end of World War II as US Army intelligence officer, and died in 1998), a key figure in industry-funded tobacco research, was praised in a CDC publication for his achievements in tobacco research. In this obituary he was presented as a martyr for his determination despite having to "endure" "years of criticism from the tobacco industry and scepticism from many researchers".[582] In another obituary by his friend and colleague Dietrich Hoffmann and his wife, he was praised for his "pioneering" role in linking lung cancer to smoking in 1950 (as a German speaking scientist, though, who was in Germany in the early 1940s, he must or should have known about the numerous earlier German studies on this issue, *see Chapter 7*), his numerous awards and honorary degrees and his merits for public health in the United States,[583] but not even one word was said about his being funded for more than 30 years by Philip Morris[584] and the German Verband[100 182]. Not only his studies were funded by the tobacco industry but also the establishment of his American Health Foundation.[583] Wynder himself never acknowledged these relationships to the industry. The article by Fields & Chapman on Wynder's relationship to Philip Morris disclose the industry's efforts to influence this leading scientist by "courting" him "with large equipment loans and grants for more than 30 years" – certainly not for altruistic reasons.[584]

However, to Wynder's credit it must be said that, at least in the beginning of his career, he seemed to be rather on the anti-smoking side[100 182], convinced about the relationship between smoking and lung cancer. However, like Kunze, it seems, he has been playing a double role: Although receiving generous funding from the industry, he continued giving anti-smoking lectures to students "to keep up his credibility among medical authorities", as cited in an industry document[120]. As many other scientists he believed in the benefits of low-tar cigarettes as a major public health political measure and did not believe in any causal relationship between passive smoking and disease. In particular regarding these two last mentioned views he was very valuable for the industry, who finally must have seen rewarded for its long "courting", facing a very good cost-benefit ratio (see, for example, the Vienna hearing). *(See also Footnote n in APPENDIX U)*

Box S-1 Participants and addressed topics at the Vienna Passive Smoking Hearing 1987

Participants (speakers)[339 341]

Austria

M. Kunze (Institute of Social Medicine, University of Vienna)
C. Vutuc (Institute of Social Medicine, University of Vienna)
H. Klus (Austria Tabak)
K. Sinzinger (II. Medical Clinic of the University of Vienna)
B. Raschauer (Faculty of Law of the University of Vienna)

Germany

F. Adlkofer (Forschungsgesellschaft Smoking and Health)
K. Überla (Institute of Medical Information Processing, Statistics and Biomathematics, Grosshadern Hospital, Munich)
G. Lehnert (Central Institute of Occupational Medicine, University of Hamburg)
W.T. Ulmer (Director of the Med. And Outpatient Clinics of the "Bergmannsheil" hospitals, University of Bochum)
J. von Troschke (Department of Medical Sociology, University Freiburg)
H.W. Letzel (Society of Medical Information Processing and Statistics, Munich)
K. Norpoth (Institute of Hygiene and Occupational Medicine, University Essen)
B. Junge (Institute of Social Medicine and Epidemiology of the BGA, Berlin)
D. Henschler (Institute of Toxicology and Pharmacology of the University of Würzburg)
H. Remmer (Institute for Toxicology, University of Tübingen)
S. Tanneberger (Central Institute for Cancer Research, Academy of Sciences of the GDR, Berlin)
P. Cremer (Centre for Internal Medicine, University of Göttingen)
M. Kentner (Institute for Occupational Medicine, University of Erlangen)
[K. Thurau (Physiology Institute of the University of Munich) – initially proposed but not among the speakers]
[H. Valentin (Institute of Occupational and Social Medicine of the University of Erlangen) – initially proposed but not among the speakers]

United States

D. Hoffmann (American Health Foundation)
E.L. Wynder (American Health Foundation)

Others

D. Hugod (National Board of Health, Department of Hygiene, Copenhagen)

Topics addressed[341]

Passive smoking as a source of conflict in society (J. von Troschke)
Concentration of tobacco smoke constituents in rooms (H. Klus)
Intake of tobacco smoke constituents by non-smokers (D. Hoffmann; H.W. Letzel)
Toxicology of passive smoking (H. Remmer; K. Norpoth; F. Adlkofer)
Epidemiology of passive smoking with particular reference to lung cancer (B. Junge; C. Vutuc; S. Tanneberger; K. Überla; E.L. Wynder)
Cardiovascular diseases (H. Sinzinger; P. Cremer)
Chronic obstructive lung disease, pulmonary function (M. Kentner; W.T. Ulmer)
Effect of passive smoking on children (C. Hugod)
Bans on smoking at the workplace and in public places (D. Henschler; G. Lehnert; B. Raschauer)
Summing-up by K. Steyrer and E.L. Wynder

The hearing

In his inaugural address, Löschnak pointed out that he would receive increasing complaints from the public about the coercion arising from passive smoking. Non-smokers would complain of being exposed to hazards of smoking in many places. Some would even sense a threat to their health and thus vehemently demand restrictions of public smoking or making non-smoking a public code of conduct. "If there is cogent evidence that passive smoking creates lung cancer, it is my task as Health Minister to protect passive smokers adequately", so Löschnak said.[343]

This symposium, so Löschnak continued, would clarify this question. A number of "internationally renowned experts" were invited by the Health Minister (avoiding mentioning the fact that *Austria Tabak* had in fact organised this meeting). These experts, whose research dealt with passive smoking, have not come to the same conclusions, so Löschnak noted. The Health Minister pointed out that the "helplessness perceived by some non-smokers against the thoughtlessness and inconsiderateness of some smokers" had possibly contributed to the fact that "the recent demand for an increase of smoking bans" would have been brought forward "so vehemently". A further argument had been added, namely that of health damage by passive smoking. However, so Löschnak said, scientific standpoints would be "controversial". Following these apparent doubts, a controversial newspaper report was cited according to which the health hazards of passive smoking would be the same or even exceed those of active smoking. "Therefore, at this symposium, the arguments of experts should be heard and clarifying questions put forward." Löschnak particularly mentioned a report from the United States[c] about the health effects of involuntary smoking "which was interpreted in Austria as if it had positively proved the harmfulness for health". More exact information should be obtained at this symposium[343] (as it seemed, in particular from the industry-financed U.S. scientist, Ernst Wynder).

Given the fact that most (or all?) speakers were proposed by the tobacco industry, which even largely (though probably not wholly) controlled the participants of this meeting, including a scheme of a "balanced" or even "controlled" debate, the results of this hearing are not at all surprising.

The main results of this meeting were, in brief:[346 586]

- No proof could be found of a causal connection between secondary smoking and illnesses as scientific methods of detection would not yet be fine enough. Although some indications for illnesses were recognised, the not very logical conclusions, which were repeated several times, said that the absence of proof of cancerous effects would not mean that there was an absence of any connexion. Or, similarly: Although "indications of organic effects of passive smoking are available ... particularly as regards pulmonary and circulatory functions", no clear connexions would be identifiable between effects and illnesses.[346 586] Rather, "certain annoyances from passive smoking are equivalent to the encumbrance which would be caused by smoking one cigarette a day".[346]

- The greatest dangers were noticed among pregnant women who smoked for their children.

- Although no cancerous effects by secondary tobacco smoke "were proven", it is advised to "avoid introducing such materials into the air that is breathed".

[c] This was possibly the1986 Surgeon General's Report on Health Consequences of Involuntary Smoking.[585]

> "Tobacco smoke is a major cause of air-pollution in closed rooms. It contains substances injurious to health and/or cancer-causing substances. Since no safety limit can be defined for such material concentrations steps should be taken to avoid introducing such materials into the air that is breathed."[346]

- Another vacuous recommendation is how to protect infants and employees from passive smoking:

> "Especially for infants and employees who are affected precautions should be taken against passive smoking".[346]

- Finally, the bigger problem would be active smokers, anyway – as subsequently also reported in the Austrian newspapers[345] – thus reducing the whole problem also from a health political point of view:

> "The discussion showed indisputedly that active smoking was far more injurious than passive smoking. For politicians concerned with health affairs this means that measures to reduce cigarette consumption are of prime importance." [346]

- The discussion also touched on the problem of smoking in schools' smoking rooms. This was the only issue were concrete measures (abolition) were easy to propose although it still took a couple of years for its implementation (and not by the Health Ministry, but by the Ministry for Education).

In summary, the following measures were proposed at the symposium: [346 586]

- Above all information should be stepped up for pregnant women.

- Although it was recognised that infants should be "extensively protected", it was warned of "state-decreed measures". Instead, "appeals to parents" (later implemented in the form of leaflets for pregnant women) were seen as more "desirable":

> "Infants should be extensively protected against the effects of (tobacco) smoke. This applies especially to closed rooms in badly ventilated dwellings. Appeals to parents are desirable here. State-decreed measures will not be able to solve this problem."[346]

- Increased attention should be paid to the accumulation of harmful tobacco-smoke residues.

- As "no risk" or "danger" could be demonstrated, there was also no need for politicians to react with prohibitions. Instead, "the creation of non-smoking zones in public transport facilities and publicly accessible offices" was seen as an acceptable compromise to help individuals to make their own "decisions":

> "The fact that no clear dangers can be demonstrated, but that there appears to be a scientifically ascertainable risk, means that health politicians should react not with prohibitions but with positive measures which make it easier for the individual to decide to avoid the risk. The creation of non-smoking zones in public transport facilities and publicly accessible offices is an important step in this direction."[346]

- Finally, pointing at the ineffectiveness of prohibitions if not enforced (which would not be possible, according the Health Minister Löschnak), the introduction of "general protective measures" would be preferable:

> "Legal measures are desirable in order to avert conflicts between smokers and non-smokers. They only make sense, though, if they are effective. The right course is not to

> impose blanket prohibitions, but rather to introduce general protective measures in places of work, gatherings, public transport and offices."[346]

The report concluded with the citation of key statements of some participants (E.L. Wynder, F. Löschnak, M. Kunze, E. Rasinger) *(original translation; bolding E.B.)*:

> "Professor Ernst L. Wynder (U.S. Health Foundation): **'One of the most important measures would be to produce a cigarette which is least harmful to health.'**
>
> "Franz Löschnak (Austrian Health Minister): **'US type anti-tobacco legislation is no good because it apparently cannot be enforced.'**
>
> "Dr Michael Kunze (Vienna University): 'The experiment with 'smoking parlours' in schools has been a dismal failure. Steps should be taken to abolish them altogether.' [d]
>
> "Dr Erwin Rasinger (Vienna-OEVP Health Spokesman): 'The Health Ministry has no recognisable strategy to counter the scourge of smoking.'" [346]

A note from the Philip Morris office in Neuchâtel (based on information by telephone from Dr. Lachner of *Austria Tabak*) summarised the highlights of this meeting as follows:

> "Mr. Loeschnak expressed his opinion that (with the exception of fetuses and children) a clear-cut proof for the danger of passive smoking was missing. He therefore will not use prohibition but work by education.
>
> "The most critical speakers were Junge (epidemiology of passive smoking with the focus on lung cancer) and Remmer (toxicology of passive smoking including the synergistic effect).
>
> "Wynder brought the ETS concentrations into a broad context by saying that some of these substances are carcinogenic, however, there are numerous carcinogenic substances of origin other than tobacco smoke in the air as well. He spoke also about the acceptance of a 'zoro-threshold'." [587]

The success of the meeting seemed not surprising to the industry. A note in an industry report from the day of the meeting (Monday 2nd May 1988) reveals that presentations and discussions "went as expected":

> "According to Dr. FINK *[observer on behalf of Philip Morris]*, the presentations and discussions went as expected, with the exception that a scientist close to RJR, Prof. REMMER, kept bringing up the subject of the new 'RJR invention' which allegedly 'solves all problems for the smokers as well as for the non-smokers'." [340]

The press conference

In the subsequent press conference, held by the Health Minister Franz Löschnak, the previous Health Minister Kurt Steyrer, and Ernst Wynder *(sic)*, Löschnak concedes that passive smokers would be exposed to annoyance in public places and in the workplace; even a "certain endangering" can be observed, but a medical causal chain between passive smoking and diseases could not be established.[344]

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[d] The existence of smoking rooms in schools was heavily criticised by many participants at the symposium. This statement of Kunze is thus not revolutionary.

A main topic of this press conference was the declared abolition of smoking rooms in schools (5% of Austria's schools were reported to have smoking rooms). The proposed measure, however, could not have been less promising in its effectiveness: Doctors should be sent into schools' smoking rooms to "advertise increasingly for not smoking".[344]

Löschnak also announced "another" anti-smoking campaign, in cooperation with the Ministry for Social Affairs. Within the campaign "Healthy Austria" and its planned focus on cancer prevention, a campaign should be started in companies "which should increasingly meet the wishes of non-smokers".[344] "For the rest, so the news article continued, the Health Minister does not want to proceed with prohibitions, which often turn out to be not executable, but with educational measures."[344]

The previous health minister and chairman of the symposium, Kurt Steyrer, stressed the fact that a "clear relationship" could (only) be found for smoking during pregnancy (i.e. children from smoking mothers) and newborns in smoke-filled rooms.

Finally, Professor Ernst Wynder, the expert from the United States and key figure of the whole symposium and who, incidentally, has been one of the most prominent scientists being funded by Philip Morris[584] and the VDC *(Verband der Cigaretten Industrie)* for many years (the industry also financed the establishment of his institute, the American Health Foundation)[120 588], confirms decidedly that there would be no proof for the development of lung cancer by passive smoking. One of the most important measures, so Wynder says, would be the development of an "as little health-damaging cigarette as possible" and health education at schools, following the example in the United States.[344]

Altogether, the meeting was definitely a success for the tobacco industry, as documented in a confidential industry report of July 1988 where Dr. Klus from *Austria Tabak* (the main organiser and involved also in the contents of the press release) stated that the media's response to the conference was "generally good".[589]

APPENDIX T

Current tobacco policies as described by the Austrian State Secretariat of Health

The following notes were taken at a meeting with the Austrian State Secretary of Health, Dr Reinhard Waneck, and an official (an expert in tobacco control) from his Office.

Asked why he would be against a substantial increase in tobacco taxes, Waneck referred to the issue of smuggling and the probability of decreasing state incomes, while advertising a cautious step-by-step policy.

> *"Because we have a high volume of contraband sales from our neighbouring countries, and it is feared that revenues would de facto decrease without having achieved a useful effect." [Despite international evidence?] "Well, here we abide with the EU regulations and do this step by step ... the tactics must be reasonable".*[288]

Confronted with the present relationship between the government and *Austria Tabak* and the latter's involvement in tobacco control policies, he admitted that previously this was indeed the case while now one would, of course, talk and negotiate but decisions would be taken by the government alone (a fact that has not been doubted even in the past, as the company itself could of course not make policy decisions but rather influence the decision making process).

> *"No more. We have had talks, though, but not when concrete changes were concerned. Whatever we have decided was done on a pure ministerial level."*[288]

Nevertheless, as soon as it comes to discussions about smoke-free public environments, for example, *Austria Tabak* is seen as one of the three main parties to be negotiated with, as the responses of an increasingly distressed expert from the Office of the State Secretary show. The statements are given in the form of extracts from notes of this meeting.

Why has Austria been so reluctant in the implementation of the recommendations of the Warsaw declaration and the WHO-FCTC?

> *"No, it is an honest concern of our policies and this government and .... and it is assiduously worked on it .... We even have employed a specialist department to ... ahem... to solve this from a legislative point of view.... What is certainly the case in Austria is that we do not now militantly... ahem ... militantly ... ahem ... rush things up which ... might even be detrimental to the actual behaviour."*[298]

What will Austria do in particular with regard to the implementation of planned EU regulations?

> *"Certainly there will be a protection of non-smokers. We are developing it, we have ... there is ... a time limit in which .... in which we have ... ahem ... to implement the directivee, I think it will be end of next year, if I am rightly informed. ... and now we are just working on this directive to ... formulate it in a way that we really get something sensible and useful, where these four or five points, these core points of this guideline, will be optimally implemented."*[298]

Asked about which points in particular he is referring to (advertising ban, etc.), he could not say (despite it being 'assiduously' worked on). This would still be too early as there would cer-

tainly be "several interests" involved which had to be considered and which would "confine the government's activities". When asked in particular about the protection of non-smokers in restaurants and cafés, these important parties became more obvious.

> *"These are things that have to be voted ... it would be untimely to comment on it because ... there are .... ahem ... many involved parties. One will have to negotiate with the hospitality industry because ultimately ... nobody should be missed out, you see .... only under the condition that there should be an appropriate protection for non-smokers, of course. But this is still to be negotiated ... the State Secretary will negotiate in this question with the various parties in person..."*[298]

Who would be these involved parties, apart from the hospitality industry? *Austria Tabak*, perhaps?

> *"Yes, of course, but also the advertising industry, ... Well, all those concerned."*[298]

What about a population survey?

> *(long pause) "... well, ... yes ... ahem ... ... I mean, we* ***are*** *willing to do something, you see. It is an issue which ... bothers quite a few and ... and many experts have already found their way to us [sic], and also we have been looking for ways ... Presently this will be registered and ... and ... will proceed into the phase where it will be worked out and then ... then we shall also locate concrete goals. But, as I said, presently this is too early..."*[298]

Sooner or later, in almost every discussion on smoking restrictions, the comparison of smoking with alcohol and cannabis or other drugs is made even by "tobacco control experts".

> *"Look here, we have prohibited hashish. You may not smoke it in restaurants or bars but you know how much hashish is consumed. This is a principal problem of addiction. Well, personally I do not think much of now heavily browbeating smokers, as in the United States."*

APPENDIX U

Serving two masters: a story of success

Michael Kunze, known by many as the most "vehement" anti-smoking advocate and long-time consultant to several health ministers, by others as the "big blocker" of effective measures, but presumably only to a few as in receipt of industry funding for decades, is a key player in Austrian tobacco policies. The following sections analyse his role with regard to the modest achievements in (or failure of) tobacco control policy in Austria.

Although when teaching at the University of Vienna as professor of public health, he uses slogans such as "if smoking would have been invented today it would be forbidden" and demonstrating 'up-rightness' towards the tobacco industry[590] (in a way that may be considered reminiscent of Ernst Wynder from the American Health Foundation, one of the most important scientists working for the industry along with whom Kunze is often cited in industry documents *[see later]*, who attempted to keep up his credibility among medical authorities[a] [120]), thus demonstrating his status as one of the most vigorous smoking adversaries, there is little evidence of a willingness to advocate effective measures to reduce smoking. His statements in the media, where he is usually cited as "the" Austrian tobacco expert, are very general, or "balanced" to the extent of insignificance[265], or even in line with the tobacco industry[349]; his publications concentrate on diagnostics and therapy, promotion of *snus*, and, at least in the past, of the role of "less harmful cigarettes" in reducing risk of lung cancer *(see later)*. At least over recent years, no proposals for effective tobacco control measures, such as smoking bans, price rises, population-wide anti-smoking campaigns, or any tangible projects are coming from his institutes. As noted, there seem to have been few activities, even in the area of smoking cessation, despite the view projected by his two institutes that they are the only real contacts on this issue (for Austria as a whole and Vienna in particular). However, he has established quite a powerful position for himself and his institutes[b] in relation to smoking cessation. In addition, by equating Public Health with Social Medicine and thus him/his institute, he has maintained a 'gatekeeper function' with regard to public health knowledge for a very long time. This may explain why evidence on the health hazards of passive smoking, smoking cessation, etc. have not been well known in Austria, contributing to a failure to implement effective measures.[591] Employees of his institutes, which have meanwhile developed as a 'family enterprise', have been occupying many leading positions in public health, health promotion and, of course, organisations dealing in anti-smoking measures. He has thus established his position as "the" tobacco expert in Austria.

When in 1997 the miners' insurance company established the *Josefhof* in Graz, a treatment centre for severely ill nicotine addicts, it was based on a concept developed by his institutes which are also entrusted with the evaluation of this project.[c] More important, however, is the fact that Kunze pushed very hard for the funding of this treatment centre as a health promotion *(sic)* project by the Fund for a Healthy Austria. After initial opposition from the Fund, political pressure increased until it was accepted.[591] Until today, the *Josefhof* as well as all other "preventive" treatment centres which have adopted this concept, have been advertised by both

[a] See Footnote b in APPENDIX S.

[b] Institute of Social Medicine of the University of Vienna and Vienna Nicotine Institute.

[c] This concept of equating smoking prevention with the treatment of already ill smokers can be traced back to the 1974 report[592] *(see later)*.

health politicians and representatives of the health insurance funds as *the* "model" health promotion projects on smoking cessation for adults which should be followed by other insurance companies (instead of other promotional or preventive measures).[591]

Following his earlier belief that "light" cigarettes are a less risky alternative for smokers, Kunze is now propagating smokeless tobacco for smokers who cannot quit smoking. While Kunze's studies on risk reduction in lung cancer by smoking low tar cigarettes were funded by the Austrian and German tobacco industry, his present deep engagement in securing the market for Swedish *snus* is conspicuously in the interest of the Swedish tobacco industry. But his generally pronounced concern for smokers who would be prepared to reduce rather than quit smoking must also be appreciated by the Austrian tobacco industry.

Finally, his (and thus also his institutes') rejection of all cessation techniques except for NRT are consistent with the interests of the pharmaceutical industry.

Whatever his role might have been in the past (see later 1974 report on smoking and health), Michael Kunze's role over many years has been defined by his refrain from action to promote effective anti-smoking measures[591], giving ambiguous or vacuous statements (as, for example, to the effectiveness of health warnings on cigarette packs[265] or the introduction of enforceable smoking bans in workplaces, evoking a scenario of raids with blue flashing lights and sirens[d593]), the neglect of passive smoking (or, with the help of Ernest Groman, aiding the controversy on it), support for medical services rather than anti-smoking campaigns or other preventive measures, in particular his presenting the health promotion community by presenting the *Josefhof* as the model smoking prevention project, his promotion of legalisation of smoke-less tobacco as an alternative for heavy smokers, his promotion of high-dosage and long-term NRT treatment for heavy smokers, advertised as "controlled" smoking (all measures only targeted at heavy or already ill smokers), and his claiming things that do not exist[e] while devaluating other measures[f]. In summary, therefore, Kunze's actions can be seen as at least consistent with the interest of the tobacco industry, as listed in Box G-2 *(APPENDIX G)*.

Indeed, one can observe that almost everything that is related to these two institutes is characterized by ambiguity, often appearing to be in the interest of the tobacco (or pharmaceutical) industry. In particular, displaying diffidence and even abstinence from action continuously over many years, while simultaneously claiming to be the only experts in Austria, cannot fail to be

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[d] In an interview for the Austrian news magazine *Format* on smoking in the office, entitled "We do not want inspectors with blue flashing lights and sirens", Kunze's advice is: "Social pressure can set many things in motion". After indicating with three words that he would be in favour of a smoking ban, because it would also be in the interest of the companies, he (as usual) modifies his statement immediately when asked by the journalist "without exception?" Kunze: "An absolute smoking ban would not be feasible, anyway. Especially in larger companies there must also be opportunities for smokers – a smokers' cubbyhole *[Raucherkammerl]*. The journalist suggests that a total smoking ban would also be difficult to control. Kunze: "We do not want smoking inspectors, driving up with blue flashing lights and control like in a raid *[sic]*. Much more important is the creation of awareness in the companies. Developing social pressure on smokers can bring about much more." Journalist: "Prevention instead of restriction?" Kunze: "We must increase information. Fortunately, many companies are meanwhile offering cessation courses to their employees." Journalist: "Do you think that these sort of projects are sufficiently supported?" Kunze: "I had talks with Health Minister Rauch-Kallat recently. She realises the necessity of treatment of smokers *[sic]*; so do the social insurance funds. I think here one is on the right track."[593]

[e] For example, while Groman declared the short introduction of a help-line in Vienna in the past (3 hours a day) as a 'failure', Kunze, himself member of the respective EU Regulatory Team on Tobacco, showed deep disappointment when the new warning labels on cigarette packs did not include any information where help could be found (indeed, where?) – obviously missing his institute as the main contact address.

[f] For example, the proposal of sanctioning violations of smoking bans like fines for wrong parking he just took as a joke without even discussing it.[303] He also devaluates smoking bans, "balances" the effectiveness of large health warnings, etc *(see above)*.

appreciated by the industry. Indeed, as several documents, mainly from the Philip Morris Archive, reveal, Kunze's efforts in blocking effective measures have been appreciated from the industry for many years. It is unclear, though, if and when the "shift" took place. The following chronological overview presents examples of Kunze's relationship to the tobacco industry. A more detailed review of documents of the tobacco industry with regard to the relationship between science and industry can be found in the following section.

A 1974 report, in which Michael Kunze was one of the three authors and which was commissioned by the Austrian Health Minister Dr. Ingrid Leodolter, caused the tobacco industry to prepare an "objective" answer to it[594], in particular since "Mrs. Leodolter seems to be in close contact with the German Minister of Health, Mrs. Fokke", and to arrange a meeting of a U.S. Philip Morris team with the Austrian Monopoly in Vienna "for discussing the 'Smoking and Health' situation in this country"[595]. Only half a year after the report was issued, Kunze was among the invited guests at the meeting of the industry's Tobacco Working Group in September 1974[330 596]. The 1974 report also speaks quite openly of the collaboration between Science (in particular the Institute of Hygiene of the Vienna University), Austria's Health Authorities and *Austria Tabak*, of encouragement of further development of a 'less dangerous' cigarette. It cites the work of the Tobacco Research Institute of the Cigarette Industry as a positive example of research in Germany.[592]

From 1978 onwards his studies, dealing with the relationship between tar level of smoked cigarettes and lung cancer (dose-response relationship; risk assessment; threshold limits), were at least of considerable interest to and in some cases funded by the tobacco industry.[597 598] He aroused concern in the industry when his intention to go public with certain brand names that would be more dangerous than others (results from a study that appears to have been industry-funded) was reported by Hubert Klus in an industry meeting.[120] While subsequent events are unclear, Kunze seemed to have reconsidered his decision and no publications could be retrieved where he blamed an internationally renowned brand.

In a 1982 publication of *Austria Tabak*[71], as well as in several industry documents[120 551 599], he is cited along with Professor Ernst Wynder, President of the American Health Foundation and one of the most prominent scientists working "under cover" for the industry. In this company publication, Kunze and Wynder are cited for their expertise on passive smoking, being of the opinion that "in spite of these works scientifically unequivocal and objective proof of damage to health from passive smoking has not yet been furnished by any population group".[71]

Michael Kunze and Christian Vutuc also were among the speakers in the industry-organised 1988 "Vienna Passive Smoking Hearing", in the company of scientists known to be either industry-funded or at least not hostile to it *(APPENDIX S)*.[341]

In 1989, an offer from Kunze to *Austria Tabak* to fund a two-year study (ATS 900,000 = € 65,400) on possible epidemiological effects of less harmful cigarettes[600] provides evidence of Kunze's financial relationship with the tobacco industry. [601-604] Two months later, this proposal was discussed at an industry meeting and the VDC *(Verband der Cigaretten-Industrie)* contributed DM 50,000 (approx. €25,000) without wishing to be mentioned officially *(see further down)*.[605]

In a 1993 internal industry paper one can read about Kunze's "very balanced" views on ETS exposure in a Vienna symposium. His views have not changed in the light of growing evidence of the harm caused by passive smoking. In this paper it was also mentioned that the "Austrian newspaper reported in a rather peaceful and balanced way" about what was, for the industry, a very successful symposium.[606]

In a 1994 report from R.J. Reynolds, Michael Kunze and Christian Vutuc were named as the two opinion leaders for Austria: "both scientists are good acquaintances of Dr. Klus of Austria Tabakwerke".[607]

On several occasions, Michael Kunze and Christian Vutuc[g] were among the invited speakers or participants in industry-organised symposiums, in the company of scientists well-known to be working for the industry (such as Ernst Wynder, Klaus Thurau, Klaus Opitz, Franz Adlkofer, etc.).[606 607] Noteworthy also is their involvement in the previously mentioned, industry-funded and, covertly, industry-organised 1988 Passive Smoking Hearing in Vienna[341] *(APPENDIX S).* They appear, however, not among the "critical" speakers in industry documents.[587]

More recently, Kunze's involvement in pushing for the legalisation of Swedish *snus* in Europe (together with the Swedish scientist Karl Fagerström and others) has been meeting international criticism.[66 351] His engagement in this matter even lead to publication in libertarian media where the interests of commerce are promoted, reading like an attempt to secure a market for Swedish *snus (see following section).*[608]

On the international stage, Kunze has also been holding important positions. Alongside leading anti-smoking activists, he was on the international editorial board of the journal *Tobacco Control*, a member of the International Union Against Cancer (UICC), a member of the WHO Permanent Advisory Panel on Smoking and Health, the national representative of Austria at WHO in the FCTC process, a member of the European Medical Association on Smoking or Health (EMASH), possibly he occupied other positions as well.[184 609 610] He has also become a member of the EU Regulatory Committee on Tobacco and has been participating in the EU Expert Tobacco Working Group.

Similar to his role within Austria, the few references to him in presentations at international conferences reveal either rather harmless statements (e.g. that the FAO report about the economic significance of tobacco would be "alarming"[609]), or uncontroversial presentations (e.g. about the development of lung cancer rates in Austria). Nevertheless, his image on the international stage contrasts with his position at home where he demonstrates a clear tendency to miss opportunities and a failure to support effective tobacco control measures.

[g] Christian Vutuc is Austria's expert in cancer epidemiology. Previous joint publications with Michael Kunze on lung cancer were mostly based on comparisons between normal and light cigarettes; as already discussed, these studies seem to have been financed by the Austrian tobacco industry. It is no secret that both are close friends with the head chemist Hubert Klus from *Austria Tabak.*

With a little help from my friends... Industry-influenced and industry-funded research in Austria

This chapter describes in chronological order parts of the industry-related career of Michael Kunze and other scientists with links to Kunze found in various industry documents.

Michael Kunze (and Christian Vutuc)

In 1974, Michael Kunze, then still a research assistant of Professor Flamm, was one of the three authors (Flamm, himself, and his brother, M.J. Kunze) of a study on smoking and health in Austria, commissioned by the Austrian Health Minister Dr Ingrid Leodolter. This report was translated by a Philip Morris employee and the preparation of an "objective answer on it" was proposed by the European Philip Morris office. "This answer or at least part of it, could be used in other countries too".[594] Half a year later, another inter-office letter from Philip Morris Europe said that the translation into English was "necessary, because the Austrian Minister of Health, Mrs. Leodolter seems to be in close contact with the German Minister of Health, Mrs. Fokke."[595] It was feared that this report would "serve as a basis for possible legislation in Austria". Thus, a meeting between D. Hoel, A. Holtzmann and someone with the initials PI from Philip Morris USA with the Austrian Monopoly in Vienna was arranged during their planned European trip "for discussing the 'Smoking and Health' situation in this country".[595]

The study itself claims to be "an inventory of the situation in Austria", taking into account "health-political decisions", and, while other reports "usually *[would]* not contain solutions of this problem", this would be one of the purposes of this report *(original citations)*. The remarks on passive smoking (no risk-association, though possibly annoying and "therewith a trouble of the well-being" for a lot of people, suggesting a tobacco allergy in some) may be excused by lack of knowledge at that time. Apart from suggesting the necessity of having recognised experts and the establishment of an institute for advice on cessation (established for Kunze himself a couple of years later), the strategy is not clear, even in 1974. Being destined for the Health Minister, to whom Kunze and, it can be assumed, the head of the institute had a very good relationship, the report is formulated very 'cautiously'. While suggesting price policy measures (but pointing also to the problems of smuggling), restrictions in the sale of tobacco products, importance of opinion leaders (parents, teachers, medical doctors, and politicians), one also finds suggestions that "all efforts to make tobacco smoking 'less dangerous' must be recognised and encouraged (despite the already recognised danger of increased female smoking, the possible increase in the quantity of smoking, and unclear effects on willingness to stop smoking) and research had to be intensified and continued, including technologic developments of cigarettes. Among the positive examples from the German Federal Republic, the work of the Tobacco Research Institute of the Cigarette Industry, Medical Working Group "Smoking and Health", is cited.[592]

The close collaboration between the Institute of Hygiene of the Vienna University and *Austria Tabak* is also interesting. It is referred to the 1973 "symposium" on tobacco control in the institute, "in which besides representatives of the Science and Health Authorities, also representatives of the Austria Tabakwerke participated". Furthermore: "These discussion partners will continue to work in the working group 'Smoking and Health' of the Austrian Society for Hygiene Microbiology and Preventive Medicine, created in March 1974". *(Original citations)*[592]

The chapter on "proposals for Austria" includes a typical Austrian concept, representing an "objective with which all interested groups can identify themselves". A tax rise would be justifiable whereby "the fact that the Austria Tabakwerke are owned by the Austrian Republic is to welcome, because the Health Authorities have to handle with one single manufacturer and can consequently find a collaboration" *(original citation)*. The report concludes with the importance of opinion-leaders, of "preventive care of the persons in danger through tobacco" (i.e. smokers), and of further reduction of harmful components in cigarette manufacturing.[592] Thus the proposed strategy seems to have been very much in the interest of both M. Kunze and the Austrian tobacco industry.

Already in this 1974 report, a list of brands with nicotine and tar levels, and frequency of smoking certain brands by sex was given[592].

In September 1974, only half a year after the release of this report, Kunze was among the invited guests at the 15th meeting of the industry's Tobacco Working Group, presenting highlights of the public health aspects of smoking in Austria, based on the results of the 1974 report. He reported that smoking and health research was supported by the Austrian Tobacco Monopoly, that there was a decrease in nicotine and tar content in Austrian cigarettes while smoking-related diseases seemed to increase, and that there were no strong anti-smoking activities by the Health Department, although with the commissioning of this report a "coordinated effort" was undertaken, "including all phases of the tobacco aspect".[330] It was stressed that, in Austria, goals in tobacco control were to market a new, lighter cigarette containing less than 12mg tar and 0.48mg nicotine, to stop advertising of non-filter cigarettes and discourage their sales; to publish tar and nicotine content on cigarette packs, and eventually to raise prices of cigarettes. These steps would be taken jointly by the Department of Health and the tobacco monopoly.[596]

From 1978 onwards, his studies have been of considerable interest to the tobacco industry. They deal with the relationship between tar level of smoked cigarettes and lung cancer (dose-response relationship, risk assessment, threshold limits of tar levels). In 1978 he published a study on smoking habits of patients with bronchial carcinoma with regard to duration of consumption and tar level of cigarette brands.[598] In 1979, Kunze and Vutuc produced a report for *Austria Tabak* (with a note "strictly confidential, not published yet") about the threshold for tar exposure.[597] The study objective was "to quantify the individual tar exposure of patients and controls accumulated during the whole smoking career considering all changes of smoking habits. This Tar Exposure Figure (Kunze, 1975[611]) represents the sum of all tar yields of all cigarettes ever smoked by the single smoker".[597] The authors, however, do not speak of a "safe" or "no risk" threshold but of a "range of very low risk which might be even a tolerable risk for the smoker".[597] With regard to lung cancer epidemiology, the results of this study show that, while tar exposure below 500 is only associated with a risk of squamous cell carcinoma, tar exposure of 501 to 1000 is linked with increased risks for Kreyberg I tumors, and higher tar exposures correlate with increasing risk for this type of lung cancer. Tar exposures of 2000 and higher also raise the risk for group Kreyberg II tumors.[597]

Kunze & Vutuc demonstrate their desire to equate health policy with smoking of low tar cigarettes:

> "To check whether this figure is realistic and a feasible goal for health policy the following calculations might be of some value. If the average Austrian smoker who consumes 30 cigarettes a day smokes the leading brand (HOBBY, 25% market share) for 30 years he gains a tar exposure of 1800 which is still quite high.
>
> "A young smoker who starts with a low tar cigarette and smokes only one pack per day and stops smoking after 20 years gains a tar exposure of 400 which is somewhat below the

> threshold. This assumption of a smoker's career is quite realistic because the two leading low tar brands are the favourite brands of some 30% of the Austrians age group 16-29.
>
> "But there are still the hard core smokers especially among low educated men. In the age group 50-59 still 15% of all smokers prefer non-filter high tar cigarettes and smoke at least a pack per day and have been doing so for an average of 35 years. This combination leads to a tar exposure of over 2000 and makes them becoming lung cancer candidates. We may conclude that there are already cigarette brands on the market which could be of some influence on lung cancer epidemiology.
>
> "Moderate daily consumption and a relatively short smoking career are the necessary provisions. Anyway the undoubtable progress in the reduction of tar exposure will be too late for many smokers who have already gained a high risk by their previous smoking habits. If we come to the conclusion of a threshold or similar low risk definition the next step means health policy, precisely product modification and maximum tar yields." *(Original citation)*[597]

Interestingly, the very few citations they use included only two external publications, by Hoffmann & Wynder[612], both being financially closely linked to the tobacco industry (in particular the German Verband, *see above*) and Gio Gori[613], director of the National Cancer Institute which, throughout the 1970s, worked hand in hand with the cigarette industry to develop "safer" cigarettes, with Gori being the leading proponent of "safe" new generation cigarettes.[115] Kunze was associated with the National Cancer Institute in the 1970s, as seen in publications and attendance at meetings. Tar-yield publications by Vutuc and Kunze were published in *Preventive Medicine*[602] (founded by Ernst Wynder) and the *Journal of the National Cancer Institute*[601] (Gori).

It is also noteworthy that Christian Vutuc is still doing research on changing lung cancer epidemiology following increased low-tar cigarette consumption, with the results (different cigarettes causing different types of cancer)[126] being considered as something 'new' in Austria.

There is some evidence that these studies were supported by the industry, as the following 1980 letter from an RJR counsel to a PM counsel, suggests. The letter discusses concern by the *Verband der Cigaretten-Industrie* (VdC) about any findings (seemingly from industry-financed studies) implicating tobacco as a hazardous product that might be published in the *Beiträge zur Tabakforschung International*, the industry's tobacco research journal. After discussing research proposals from various scientists, there was also "mention of an Austrian Professor Kunze who relates tar levels with lung cancer".[120] As reported by Hubert Klus from *Austria Tabak*, who is a close friend to Kunze, about the situation in Austria, a problem was seen in Kunze's going public with "tar exposure numbers" (the dose-response relationship between tar exposure and lung cancer). An "additional problem with Kunze" was seen in his publicly identifying certain brands as dangerous.[120] Klus further reported about Kunze's intention of submitting a detailed report to the Austrian Health Ministry for publication on occasion of the WHO non-smoker's day on April 10, 1980.[614] [h] *Austria Tabak* was preparing a defensive position paper which was also likely to be published.[614] In a memorandum nearly two weeks later from Robert Seligman (PM scientist) to Alexander Holtzman (PM counsel) one can read: "Professor Kunze's (of Austria) exposure numbers and inferred relationship to the likelihood of cancer is an extremely dangerous development. It makes the Hertefeld Index and the Gort Indix child's play. It is particularly damaging if he publicly cites specific brands. On the subject of Beiträge *[Beiträge zur Tabakforschung International]* it would be most unfortunate if this publication ceased. It is the one publication of international stature within tobacco technology groups. Listing smoking with other chemicals is an unfortunate precedent. I'd hate to see 'threshold limit-

[h] At the time of finishing writing up this thesis it could not be found out if this study was indeed published or not.

ing values' for Marlboros in U.S.A. Industrial sites. I'd be pleased to have your comments on the above."[120]

Although there is still an Austrian website providing a questionnaire with three categories of cigarettes (with examples of popular brand names) and inviting the smoker to calculate his/her health risk[615], no publication by Kunze could be retrieved where he identified a particular (international) brand as more dangerous than another. He seems to have reconsidered his initial intention.

In 1981, more publications based on the 1978 study on smoking habits of the Austrian population followed (part A and part B). These publications read like a report for *Austria Tabak*, describing in detail which brands are smoked by whom. They were published under the name of his colleague, Brigitte Gredler. There is no denunciation of Marlboro or any other international brand but only references to "cigarettes with a high level of harmful substances". The only brand which is named are the two (obviously innocuous for Philip Morris) Austrian home brands "Austria 3" and "Austria C".[616 617] Similarly, part B of the report, dealing with exposure to smoke condensates by Austrian cigarette smokers[604], only lists brand names but does not cite threshold limits. The future development of his own studies can be discerned when reading the second recommendation for intervention regarding tobacco-related diseases and smoking prevention:

1. Introduction of an upper limit of harmful substances, to be reduced over time (elimination of cigarettes with a high level of harmful substances). Citing of other studies by Kunze that the changeover to lighter cigarettes does not necessarily mean an increase of quantity of smoked cigarettes.

2. Preventive measures to be targeted at "high risk groups": In the process of looking for smokers with tobacco-related disorders (in particular bronchial cancer), individuals should be given the possibility to take part in a cessation programme for heavy smokers *(sic)*.[604]

In a special 1982 edition of *Austria Tabak Information* about smoking and health, destined for the company's employees to provide them with a "balanced information" and an "argumentation basis" for "talks with friends and acquaintances, in discussions", the importance of Kunze's research becomes more evident. Apart from many arguments, which still feature in public opinion and which are still used by Mauhart in television discussions,[i] the focus is on the responsibility of the firm to reduce the harms of smoking by developing and marketing "the modern, light cigarette".

> "This already shows, in the view of many scientists who must be taken seriously, a favourable influence *[of light cigarettes]* on the extent of the health risks attributable to smoking.
> ...

[i] These arguments include: Tobacco is a luxury good like tea or coffee, every culture possesses its specific stimulants and their consumption are something specifically human, the sum of all vices remain constant, cigarette smoking is "pure enjoyment" which is "difficult to describe" but has "undeniably positive effects", there is no "chain of causality in the strictly scientific sense between cigarette smoking and illness", all being a "question of mutual consideration and tolerance (and of ventilation)", distinguishing "tolerant" non-smokers versus "fanatical anti-smokers", freedom to decide whether, "to improve the quality of life", "adult and articulate people in this country" should "continue to consume a stimulant that for centuries has been a component of our civilisation". In particular it is stressed that, with the development of a less harmful cigarette, the tobacco industry has done more for risk reduction of smoking than any intervention by health policy.[71]

> "Austria Tabak takes the smoking – lung cancer question very seriously. Practically the whole research capacity of our firm and that of a number of other tobacco industries is at work mainly in this field."[71]

More light is thrown on Kunze's views on passive smoking, when he is cited, as so often, on the side of the industry-funded scientist Ernst Wynder:

> "Doctors who have been very intensively involved with the question such as Prof. Kunze (Institute of Hygiene of the University of Vienna) or Prof. Wynder (American Health Foundation) are of the opinion that, in spite of these works scientifically unequivocal and objective proof of damage to health from passive smoking has not yet been furnished by any population group."[71]

A 1983 note from the office of Philip Morris in Neuchâtel, announcing a two-day symposium on the topic "Smoking and Health" in Düsseldorf, again mentions the two scientists Wynder and Kunze as obviously being important: "The organiser of the meeting is Leo / Sweden (who are marketing the 'Nicorette' nicotine chewing gum). Prof. Wynder and Prof. Kunze have already agreed to take part."[599]

A confidential report about the programme of the 1987 Tokyo Conference on Smoking and Health is therefore untypical as speakers known for their "anti-smoking stance" were marked with two xx. Kunze, quite inexplicably, was among them.[618]

In the industry-organised and partly industry-funded 1988 "Passive Smoking Hearing" in Vienna, Michael Kunze not only attended but was on the list of those speakers proposed by the industry already in September 1987.[339] Christian Vutuc was invited later. While Kunze introduced the problem at the symposium, Vutuc spoke on the epidemiology of passive smoking with a focus on lung cancer (along with B. Junge, S. Tanneberger, K. Überla, E.L. Wynder).[341] Neither Kunze nor Vutuc were named as being among the "critical" speakers.[587] *(APPENDIX S)*

Further evidence of Kunze's relationship with the tobacco industry can be found in 1989. In May 1989, and evidently not for the first time in his career, he turned to *Austria Tabak* for financing studies on the merits of light cigarettes in reducing the risk of lung cancer, signalling "positive" and "favourable" (favourable for whom?) developments and proposing "adjustment" with experts from Germany in the field of tobacco-related diseases. In the proposal he also offered an assessment of future developments, in particular with regard to market shares of LHC (less harmful cigarettes), and identification of marginal values (threshold limits), already undertaken in his previous studies, culminating in conclusions about further product modification. The two-year study should cost ATS 900,000 (= € 665,400) – an "enormously favourable cost-benefit ratio", according to a note at the end of the document by an Austria Tabak representative.[600] It may be suspected that previous studies of his, together with his colleague, Brigitte Gredler (now married to the director of a pharmaceutical company), and Christian Vutuc (also a friend of Dr Klus from *Austria Tabak* and until today the leading Austrian expert in cancer epidemiology)[j], on the dose-response relationship between lung cancer and tar yields were also financed by the tobacco industry.[601-604]

[j] Michael Kunze, Christian Vutuc and Brigitte Gredler were at that time all assembled in the Institute for Hygiene of the University of Vienna, later in Kunze's Institute of Social Medicine. All are meanwhile holding the status of professors, with Christian Vutuc being head of the Department for Epidemiology at the Institute of Cancer Research of the University of Vienna.

Two months later, in July 1989, this proposal by Kunze to *Austria Tabak* was discussed at the VDC *(Verband der Cigaretten-Industrie)* Science and Industry Policy Committee (WPA) meeting in Hamburg. The VDC seemed interested in this project and contributed funding of DM 50,000 (approx. €25,000) for "special uses" but wished its participation not to be "official".[k605]

In a 1993 internal industry paper one can read about Kunze's "very balanced" views on the Vienna symposium organised by *Austria Tabak* (4 November 1993) where a "blend of pros and antis" speakers discussed the health relevance of ETS exposure. Among the most important were Wynder (American Health Foundation, pro-industry), Adlkofer (VERUM Foundation, VDC) and Schulte-Herrmann (Austrian toxicologist), Riemann, Thurau (both known to work for the industry), and Kunze. The symposium seemed a success for the industry. It was also mentioned that the "Austrian newspaper reported in a rather peaceful and balanced way".[606] It is noteworthy that the latter's remarkable balanced views have not changed since.

In a 1994 report by R.J. Reynolds one can read about the 'favourable scientific environment' in Germany and Austria (i.e. where scientists are giving a "scientific blessing" at the request of the Departments of Health, also with regard to 'safer cigarettes'). It even includes advice on how to deal with individual scientists, i.e. if they were "unpredictable" or if contacts had been "cultivated". For Austria, Michael Kunze and Christian Vutuc were named as the two opinion leaders, both harmless: "both scientists are good acquaintances of Dr. Klus of Austria Tabakwerke". In this report, a small scientific symposium was suggested, "heavily targeted at the (popular) scientific media"[l] and "possibly to be organized in Austria because of the much less aggressive environment there". Among the "well-acquainted" (i.e. to the industry) speakers (Ernst Wynder, Klaus Thurau, Klaus Opitz), Christian Vutuc was suggested as a speaker on an epidemiological topic.[607] Besides, both Kunze and Vutuc, were invited by the industry alongside Wynder to various smoking and health symposiums and meetings.[341 599 607]

More recently, Kunze (together with Karl Fagerström) has been calling for legalisation of the Swedish *snus* in Europe[66 351], meeting considerable international criticism from the public health community (though not from the tobacco industry). In this matter, he feels like a protagonist within an ignorant and one-sided public health community. He equates *snus* with pharmacological nicotine products which, in the beginning, met equal resistance in Austria when first proposed by him.[331] In particular, however, Kunze advertises *snus* not only as a tool for smoking cessation and a replacement for cigarettes but as a tool for preventing lung cancer in already heavily nicotine addicted smokers:

> "Swedish snus might be useful in helping highly addicted tobacco users rid themselves of cigarettes. Being heavily involved in the diagnosis and treatment of tobacco addicts, we at the Institute for Social Medicine at the University of Vienna as well as the Nicotine Institute, Vienna, are especially interested in new approaches to help those who are heavily addicted to nicotine. Our reasons are straightforward: we do so because they are the ones who not only face the highest risk of contracting lung cancer and other tobacco related diseases, but because they have also traditionally been less receptive to and responsive to established treatment procedures.

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k The note says: "Prof. Kunze Research Project. Prof. Kunze presented a project to Austria Tabak, in which the effects of modern cigarettes on the frequency of lung cancer in Austria are to be investigated (Encl.1). A financial participation by the VDC in this project was discussed. It was decided to provide DM 50.000.- to Austria for 'special uses'. Official participation by the VDC was declined."[605]

Participants of this meeting were: Adlkofer (VDC), Beecken (PMG), Elmenhorst (BRI), Dreyer (BAT), Hausen (REE), König (VDC), Kausch (BAT), Dembach (RJR), Doms (BRI), Fink (PMG).

l Although it was also indicated that a "Supplement could be arranged with the *'Münchner Medizinische Wochenschrift'* ('Munich Medical Weekly')".[607]

> "Many experts feel that since much more dangerous tobacco products like cigarettes are freely available, it is hard to understand why Swedish snus can only to be used in Sweden and not in the rest of the European Union." [608]
>
> "From a public health point of view, the availability of snus will offer another possibility to help those who cannot stop smoking -- or who don't want to do so in the near future. Of course it will be necessary to monitor the possible consumption patterns in the case of the availability of Swedish snus in countries outside Sweden." [608]

Kunze's concern, as published also in non-public health oriented media (e.g. on the free market "Tech Central Station" which is sponsored by various industries[m] and which advertises for the PFA Voter Fund for President Bush)[619], seems also to be the concern of the tobacco industry. One would easily get the impression that Kunze is trying to secure the market for the Swedish company:

> "However, the unconditional lifting of the existing ban is not necessarily the solution. Under such a scenario, even more dangerous products such as smokeless tobacco from India might be brought into the EU countries to a much great extent than before. By the way, those products are already available and not sanctioned by a ban.
>
> "Given this, it would be wise for the European Community to review the existing ban on snus, while at the same time imposing much more strict regulations on all kinds of nicotine delivery products, especially smoked tobacco." [608]

In summary, therefore, one can observe the coincidence of Kunze's research with the interests of the tobacco (or pharmaceutical) industry: support of a "less harmful cigarette"; effects of light cigarette smoking on lung cancer; diagnostis and treatment of smokers (as the optimal smoking prevention measure); EU legalisation of snuff *(snus)*.

In conclusion Kunze has been at best "harmless" or "useful" enough to be invited to industry-arranged symposiums to contribute his expertise and "balanced" views. Kunze also seems "interesting" enough to be discussed at senior industry meetings together with Ernst Wynder (one of the most important scientists working 'under cover' for the industry[n120 551 599]) and Peter Lee (an industry-funded statistician who has in the past worked with Richard Peto[o]).[621] Last but not least, his research fields appear to have been of sufficient interest to the tobacco industry to justify financial support.

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[m] This site is sponsored by AT&T, Avue Technologies, The Coca-Cola Company, ExxonMobil, General Motors Corporation, Intel, McDonalds, Merck, Microsoft, Nasdaq, PhRMA, and Qualcomm.[619]

[n] It seems, however, that in the beginning of his career, Ernst Wynder was rather on the anti-smoking side. Although being financed by the German tobacco industry already in the 1970s, Wynder then appeared not reliable "on a long-term basis".[100 182] However, he was known to believe in no causal relationship between passive smoking and disease and was thus very valuable for the industry who continued financing him and his American Health Foundation. He has since played an important expert role as physician for the industry (e.g. in contesting the White/Froeb study on passive smoking[120]; see also Vienna passive smoking hearing and Footnote b above).

[o] Richard Peto's opinion in 1983 on "less harmful cigarettes" as an "important contribution to a reduction in the mortality from lung cancer"[620] (in accordance with Lee who, in spite of some compensatory effects, argues that this type of cigarette "has its place in preventive medicine"[620]) and on passive smoking which he believed to be only a political issue without seeing a cause-effect relationship, in particular doubting the findings of Hirayama,[609] are also somewhat surprising.

Others

Rumours about the generosity of the tobacco industry in funding studies to support the industry's point of view must have spread among other Austrian scientists. In 1997, when the effect of smoking should have been known among even the most sceptical doctors, a doctor from the Vienna City Employees Medical Centre[p], Dr. Heinz Lütgendorff-Gyllenstorm, offered his services to Philip Morris in Neuchâtel. He is supported by several Austrian doctors (mainly professors), among them, by now no more surprising, Michael Kunze,[q] who hope for financial support for studies of their own. He argues that many diseases "wrongly" alleged to be due to smoking are instead caused by contact with food over 37°C. Thus smoking would be less harmful than previously claimed and his new findings could help the industry in legal disputes.[r] This would be "happy news for the tobacco industry", so Lütgendorff suggests in his letter, though possibly 10 years too late, as hinted by *Austria Tabak* before advising the eager doctor to contact Philip Morris. Obviously convinced about the far-reaching consequences of his theory, Lütgendorff's demands to Philip Morris are anything but modest: (A) Maximal research effort at 11 projects, involving the listed doctors; (B) Founding of a research institute for scientific investigation of this new risk factor; (C) Determination of a price for the scientific investigation of this risk factor; and (D) Publicity for the new risk factor. He concludes his letter unequivocally:

> "Dear Doctor *[Helmut Reif]*, I am pleased to be able to write to you in this way and would like to speak with you personally on the topic of 'How to get the best possible advantages for the tobacco industry from this new knowledge?'. I estimate that within five years the tobacco industry would save a thousand times its investment in this research. Claims for damages against the tobacco industry would have little chance of success."[622]

It is not clear if this project was sponsored by Philip Morris or not as no answer could be found in the archive of the company.

Michael Kunze and Ernst Wynder

There are some striking similarities between the previously discussed German-born American scientist Ernst Wynder who died in 1998 *(APPENDIX S; in particular Footnote b)*, and Michael Kunze, both having been celebrated as vehement anti-smoking advocates while having received funding from the tobacco industry for decades, without acknowledging it. Thus both have been used to play a successful double role where "no problem" is seen with being funded by the "enemy" and being invited to industry-organised meetings to lend their balanced/controlled expertise to the industry (either directly in the interest of the industry or at

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[p] *KFA – Krankenfürsorgeanstalt der Bediensteten der Stadt Wien,* department for health screenings. Dr. Lütgendorff is still employed there.

[q] The list of doctors include leading professors in Vienna. In particular, "maximal research effort" would be needed by Dr. Wolfgang Wlk, Prof. Dr. Ibrahim Elmadfa, Prof. Dr. Wolfgang Sperr, Prof. Dr. Wolfgang Marktl, Prof. Dr. Reinhard Krepler, Prof. Dr. Alfred Gangl, Prof. Dr. Hugo Rüdiger, Prof. Manfred Götz, Prof. Dr. Wolfram Reiterer, Prof. Dr. Friedrich Horak, Prof. Dr. Michael Kunze, Dr. Georg Stingl, Dr. Klaus Wolff, Dr. Gstöttner.

[r] The arguments brought forward to please the tobacco industry were: "1. Many diseases are primarily caused by the new RF *[risk factor]* and not by smoking. Smoking can no longer be held responsible for everything. 2. Many scientific works on the effects of smoking on health will have to be re-evaluated or repeated in the light of the new RF. 3. The new RF will have to be taken into account in expert opinion, legal disputes and claims for damages. 4. The image of smoking will be improved. Smoking is less harmful than previously claimed."[622]

least not harming it), while at the same time Wynder was one of the most renowned American scientists in tobacco research and Kunze the self-celebrated Austrian expert in smoking cessation and tobacco control as well as government consultant to several Austrian health ministers (thus cashing in on both sides). Both have been teaching as professors at the university against smoking, consolidating their status as experts. In the case of Wynder, this was done "to keep up his credibility among medical authorities" [120], in the case of Kunze it can only be assumed to be the same. Wynder has been celebrated for his "blows against the industry"[623] (with industry-funded studies), Kunze celebrates himself as the "most dangerous man for the tobacco industry". Both have been known for their power of persuasion[s], their "genius entrepreneurship" (Wynder[583] but certainly also applicable to Kunze), and being a "great communicator" (Wynder)[583] and a "publicity genius" (Kunze)[305].

As seen in various industry documents, despite receiving continued funding from the industry for many years, both were seen by their sponsors as a bit "problematic" for their research and the publication of the results.

For decades, until the 1990s and thus long after issues such as compensation and negative health effects were known, Kunze and Wynder (and Gori from the National Cancer Institute) have been in the group of those seeing the development of a "safer" cigarette as the best (or only) health political measure for risk reduction.

Both did not believe in a causal relationship between passive smoking and the development of disease. Kunze's present belief is unknown as he has essentially ignored the issue of passive smoking. However, his institute has recently published estimates of the number of deaths due to passive smoking in Austria in 2003.[349]

[s] For example, due to the usually very smoker-friendly climate in the media, even "harmless" or vacuous statements against smoking are conceived by many as "revolutionary", thus leading to the fact that Kunze in the public is perceived as very convincing and in Austria seen as one of the most "vehement" and engaged anti-smoking advocates.

APPENDIX V

Media analysis

A more detailed analysis of Austrian media coverage was performed on reports following the introduction of larger health warnings on cigarette packs in Austria in October 2003 and the introduction of a smoking ban for all workplaces in Ireland in March 2004. In addition, the two television discussions following these events were put under greater scrutiny.

Introduction of larger health warnings in October 2003

Both, politicians and the media, have ridiculed the new warnings, pointing repeatedly to their supposed ineffectiveness. Even more ridiculous and equally ineffective would be the planned use of images to accompany the warnings. Quotes from smokers who insist that these warnings would certainly not effect their smoking behaviour have been common compared to others who would accept some positive effects. The *Kronen Zeitung*, Austria's most widely-read tabloid, shortly after the introduction of the warnings, cited a poll conducted by the German news magazine *Spiegel*, whereby 79% of the respondents were "not at all appalled or distressed" by the 'deterring' new health warnings, and only 4% felt 'very' insecure about them.[624]

Similarly, one month after the introduction of the new health warnings, it was common to read of the "proven ineffectiveness" on Austrian cigarette sales, relying on information from the Austrian tobacco industry *(sic)*. In an article by the Austrian Press Agency (APA) about the increase of smoking rates particularly among women and very young people, Austria's top ranking within 7 EU countries in indoor air pollution in discos, restaurants, hospitals, schools and universities, and the success rates of smoking cessation, one third of the report (perhaps in an attempt to 'balance' the debate) was dedicated to the 'fact' that the larger health warnings introduced one month previously were obviously a failure, as sales figures did not decrease – as reported by *Austria Tabak* and the tobacconists' association. However, and this was reported at great length for all those who had not heard of it before, an interesting additional business had developed for the tobacconists: the high demand for 'protection sheaths' (or 'fag condoms'), which were brought on the market simultaneously with the new cigarette packs and which were designed to cover the warnings.[273] This message was successfully transported via other print media to the public who readily took up this argument, not questioning its accuracy. This "proof of ineffectiveness" was not only encountered frequently in discussions with acquaintances, but also raised by health politicians and government officials in the meetings.

After conceding that, since the start of a comprehensive anti-smoking campaign in California in 1989, tobacco consumption decreased by 57 percent, the already cited article in the *Profil* concluded with a statement by the Austrian respiratory physician Kaspar Sertl that it would be "unlikely that these shocking prints would produce even a fraction of this effect" in Austria. Perhaps they would even achieve an opposite effect: "The more prohibitions there are, the more interesting it becomes ... We encourage young people to start smoking."[265]

In another newspaper article, an Austrian expert on tobacco law in the EU and in Austria demurs on the legality of these measures, recalling the prohibition of harmonising action on public health in the EU and the potentially negative consequences for tobacco exports – while characterising the slogans as "brutal" and "martial".[625]

Most of Austria's media reports could thus be described as "negative advertisements" for tobacco control measures, conveying the view that nobody could think them to be effective, accompanied by "positive advertisement" for cigarette sheaths and smokers' rights.

Impressive descriptions of the new health warnings themselves were given in the *Tiroler Tageszeitung* in one of its November issues. Health warnings were described as "fat and ugly", a "disfigurement", being "schoolmasterly slogans" from the "moral industry" with its "lifelong pedagogics". According to the author, warnings of the harm from nicotine were weak arguments as the abuse of alcohol would definitely have more dreadful effects on society. After all, everything depended on the right attitude:

> "One can ruin oneself with almost everything... Enjoyed or done with right measure, almost everything can enrich and beautify life. ... That is why these slogans on cigarette packs are so annoying: Because the citizen, who mostly knows very well how to live, is being treated like a blithering idiot".[626]

In summary, the adjectives used to describe the enlarged health warnings were: fat and ugly, brutal, martial, disfigurement, schoolmasterly, shocking inscriptions, drastic death formulas, black bordered death notice, shocking prints, prospects of death, ridiculous, ineffective, trying to spoil the pleasure of smoking to smokers.

Smoking bans in public places

Media coverage on the smoking ban in Ireland was less aggressive than that of health warnings; it was handled rather like a joke or at least as something very amusing. Although the main messages of the reports addressed the fierceness of the measures and the fear that this might spread within Europe (in particular Austria), also citing the fears of restaurant owners of losing customers, supported by impressive figures for the allegedly damaging effects on the hospitality business, some papers also reported the approval of Irish non-smokers and the results of a poll according to which 81% of the Irish population would be in favour of the ban. There was great sympathy for the "tricky" solutions of Ireland's publicans in circumventing this "silly law" by installing "happy smoker buses" or shifting business outside the pub under gas heaters.

Apart from references to the United States (in particular the recent smoking ban in New York), Norway and Italy (in particular South Tyrol) were occasionally mentioned as examples to follow, but achievements in other countries were largely ignored.

Irish pubs were equated to Austria's coffee houses, where a smoking ban would be ridiculous. The owner of the well-known Vienna coffee house Café Landtmann claimed that there would be no demand for non-smoking rooms, quite the opposite: these rooms would only be filled last (in fact, as with most other famous Vienna coffeehouses, there are not even non-smoking tables or small 'sections', let alone a non-smoking room in the Café Landtmann, as checked at the end of June 2004). However, considering the previously discussed usually disadvantageous location and atmosphere of these rooms or zones (if they exist at all), and the generally negative response to inquiries about non-smoking rooms, this should not at all be surprising. The café owner even feared that the "distinctive flair" of a coffee house would be lost. The owner of the famous Vienna restaurant Steirereck declared his determination to fight any future smoking ban, preferring rather to pay the fines (which, in the case of Austria, would most certainly not exist or be very moderate, rather of a symbolic nature). He adds: "We are a pleasure temple, not a church".[627]

In New York, so some papers argued, the smoking ban would have led to dismissals of employees and to financial losses of up to 50 percent due to decrease of customers. Some establishments would even have to close down. No wonder, Austria's restaurant and pub owners, already now having "to fight for each single customer", have been "terrified" by this scenarios.[627] As in Germany, this is seen as a particular threat to smaller establishments.

A very recent report in an Austrian news magazine presents the Health Minister's announcement to enforce more rigorously smoking bans at the workplace as something enforced upon employees single-handedly, while citing that "even" the State Secretary (described as "nicotine abstinent" although being known smoking cigars[a]) "considers it extremely doubtful to criminalise smokers by rigorous regulations". Several CEOs (with photos) from known big companies in Austria are cited who stress the point of "restriction of personal liberty" (Robert Hartlauer), rely on the "self-regulation of the smoking problem by the employees themselves" and the motto of not wishing "to wean people with strict measures" (speaker of the company VOEST). Another CEO is cited for having recognised the "positive social side-effects" of smoking in his "smokers' kitchens" in every floor. The director of the National Bank is cited for smoking "at every opportunity, thus also in the office" and his tolerance, leaving his employees "to decide for themselves whether they wanted to smoke or not". The director of a museum admits that she would be a "stress smoker" being unable to deliberate without a cigarette. "Of course, my employees are allowed to smoke in my office". Only one is cited to be in favour of a ban: The medical director of Bank Austria who "believes": "The more restrictive the measures are, the less people smoke. Thus it makes sense to reflect upon a ban". After advertising for smoking cessation courses offered or paid by companies or the health insurance funds (as favoured by the Health Minister), Michael Kunze is cited with his usual "balanced view" *(as described in APPENDIX U)*.[349]

TV discussions

The first televised discussion on smoking and tobacco control measures, entitled "fight the smokers", of 5 November 2003[37], followed the "shock" of the introduction of enlarged health warnings on cigarette packs. Invited participants included the Health Minister, two health professionals, a tobacco victim, a publicly known non-smoking advocate, two publicly known advocates for smoking (or, as called in the *Profil* article, "advocates for the pleasure of smoking").[b] The discussion was dominated by arguments for the smokers' perspective and against "ineffective" tobacco control measures. In particular, the programme was dominated by the personalities and arguments of Beppo Mauhart, ex-General Director of *Austria Tabak*, and Elizabeth Spira, Austrian TV film-maker, known for her down-to-earth TV programmes representing 'real' life which have been known to both reflect and form public opinion. The latter ascended to "the new smokers' icon", as praised in the *Profil* story[265]. As a free, self-determined citizen she would not accept to be deprived of the pleasure of smoking by anyone, least by patronising politics.

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[a] Interestingly, Waneck and Mauhart, both cigar smokers, have been described as "non-smokers" in the media. Mauhart even described himself a non-smoker, having quitted (cigarettes) already years ago (by his own free will, of course – see later).

[b] In particular, the group consisted of Maria Rauch-Kallat (Health Minister); Elizabeth Spira (film producer); Hartmut Zwick (specialist for pulmonary diseases); Alfred Worm (journalist and tobacco victim); Beppo Mauhart (ex-general director of *Austria Tabak*); Karl Georg Doutlik (Austrian representative European Commission); Hans-Peter Hutter (health professional in environmental medicine); Robert Rockenbauer (Austrian association for the protection of non-smokers); Kurt Knauseder (smoker for 30 years); Margarete Lemerhofer (teacher),[37] two pupils.

> *"I am smoking because I enjoy it. I have been smoking since I was 12 years old. Every smoker knows that it is unhealthy. We are not stupid! With every drag you know that it does you no good, but it brings enormous pleasure. Three years ago I had not smoked for two years, due to reasons of health. This made me very depressive, I had gained 8 kilos in weight and my blood pressure increased. ... I started again smoking. It is not my concept of life to lead a sporting lifestyle until the age of 90. What presently is done in anti-smoking measures surely won't be successful. I don't like to be patronised. I am an adult individual who knows what's all about. I am addicted to cigarettes and not an alcoholic. One should not begrudge the pleasure to the people. Alcohol addiction and narcotic drugs are greater addictions than smoking. Smoking just wrecks myself, while alcoholics become aggressive, beat up women, bring disaster into the family etc., and narcotic drugs make you daft. Then there are also the exhaust gases of cars – thus the whole life is relatively dangerous. If we do patronise everything ... I don't want to live in a country where one is treating me like in a kindergarten."*[628]

Health Minister Maria Rauch-Kallat refused to introduce legal protection of non-smokers in the hospitality industry and stressed voluntary nature of publicans and restaurant owners offering non-smoking seats to their customers. A 15-year old female pupil stated that she was addicted and could not stop smoking and an employer prided himself of having the "luck" of employing two "tolerant non-smokers" in his office.

The second programme on 4 April 2004, again featuring Health Minister Maria Rauch-Kallat, ex-General Director of *Austria Tabak* Beppo Mauhart, the head of the non-smokers association Robert Rockenbauer, and in addition a society journalist, a physician (lung specialist), and an Austrian cabaret artist, was called an "emotional debate" on smoking bans.[38]

Again, the charismatic personality of Beppo Mauhart clearly dominated the discussion, invoking frightening scenarios about a society drowning in drugs – all of which was the fault of militant non-smokers. His domination, with "powerful" arguments which both represented and confirmed widespread opinions, made his statements worth noting. Introduced as "self-proclaimed pleasure smoker" (cigars) and 'simple' representative of smokers, he occasionally confused his position with the old General Director role.

Starting with the "free, responsible citizen", whom some politicians would wish to bring again under "state control", he argued that bans would "only bring conflict into society". With measures like these, we would move from liberalism to prohibition. Repeatedly he emphasised that giving up smoking would be a pure matter of individual willpower – and for that we would not need medical advice or therapeutic support (in contrast to alcohol, though). The Irish smoking ban he described as a "cultural shock" and "irresponsible". Again and again he was emphasising that smoking was the least problem, compared to alcohol and heavy drugs.

In a relapse to the times when he was still heading *Austria Tabak,* he declared that he would "do anything to prevent youths to start smoking" while health warnings and prohibitions would be an incentive for youths to smoke. (The generally silent presenter agrees and confirms that we have already seen their uselessness in the sales statistics.) Youths had been already "far more distanced" until the introduction of the health warnings *(!?!)*. Again, as someone who is really interested in preventing youths from taking up smoking, he urged health policy to "critically rethink" this issue because it would be "completely the wrong way"; it would all be counterproductive. The achievement of filter cigarettes, so Mauhart argued, had been a greater health political breakthrough than all other measures. The decrease of tar and nicotine yields would be "the only sensible way". The enlargement of health warnings had been ineffective for years. 'Light' brands would be "the best offer to smokers", for the "transitional phase to the non-

smoker status"; therefore, the banning of 'light' would be senseless (obviously misinterpreting the fact that only the term "light" has been banned, not the light brands themselves).

He agreed repeatedly that tobacco, like other pleasures, had to be consumed in moderation. The entire history of mankind was characterised by the use of stimulants *(Genussmittel)*, this was intrinsically human. If one falls out of fashion, another takes its place. Therefore, "all militant non-smokers" had better consider how a society that prohibits smoking would be like – an El Dorado of all sorts of (dangerous) drugs, as one could already observe in the United States.

Mauhart also did not miss suggesting the relationship between smoking and "culture" when comparing the two side-by-side cafés in Vienna's main shopping street, Kärntnerstrasse: the newly opened Starbucks and the traditional Café Sacher:

> "Nobody forbids owners of restaurants and bars to open a non-smoking establishment or a non-smoking corner. But why this is not done? Because the consumer does not accept it. An example how this is regulated in Vienna, how it functions without legislative regulations: Those who want to consume coffee are sitting in Starbucks *[speaking in plural]* and who wants to enjoy coffee with a little cigarette goes to the Sacher, which offers an according environment *[speaking in singular]*. For this we do not need a legislative regulation."

The Health Minister emphasised moderation throughout, "everything with the right measure", referring to the existing laws for the protection of non-smokers. Surprisingly, she also spoke of the right of non-smokers to dine in a smoke-free environment, mentioning also that both her father and grandfather had died relatively young as publicans. These facts, however, are obviously not enough to ensure a smoke-free environment for other possible victims. Instead, "already" half a year ago an approach by the Health Ministry to the hospitality industry was made regarding a "voluntary agreement" for smoke-free zones – at least in establishments of a certain size. She expressed satisfaction that there would at least be "enough places with a good ventilation". If there were no positive results from the hospitality industry within 12 months (unclear from which point of time), it would be possible that a legal regulation might follow. She sets her hopes in a "positive competition" as "the desire for smoke-free environments will increase". With that, she is in full accordance with Mauhart who emphasises the role of the market. Meanwhile she sees her task in appealing to reason.

The Health Minister also sees her task in appealing to those willing to quit and pointed to the offer of health insurance companies to fund therapies such as the *Josefhof* (again consistent with the tobacco industry, which is surely interested in this kind of "prevention").

Gerhard Bronner, the 82-year old Austrian cabaret artist (life-long smoker, obviously being invited as a living example that smoking is not so bad after all), doubted everything that came from Ireland, followed by oblique references to the Nazi-era and Hitler, and showed no understanding why a harmless habit such as smoking would be such an issue while alcohol was much more dangerous. Both he and Mauhart eagerly pointed to the "real" and "biggest" problems in Ireland, as read from a list by Mauhart: 1. trucks on the overtaking lane; 2. ecstasy; 3. teenage pregnancy; and 4. alcohol (whisky and beer). Nobody, though, had caused a lethal traffic accident in a nicotine-drugged state so far, so they argued.

The two most interesting results of this discussion were first, that the pro-smoker side was allowed to clearly dominate the discussion, and second, that the Health Minister and the former tobacco potentate were seemingly opponents, but in principal in accordance with each other. It also seems to be much easier for smokers and smoking advocates to sit back and appear relaxed and witty, while those reasoning restrictions usually appear serious about this issue. This became clear when analysing the video tape.

APPENDIX W

Public awareness of smoking-related issues in Austria

As early as 1981, a diminution of social acceptability of smoking was seen by the tobacco industry as the greatest long-term threat.[394] At least in Austria, however, the industry can still be relaxed, confident that it can deal effectively with the current cautious attempts to consider the viewpoint of non-smokers.

In Austria, public awareness on smoking-related issues is very low. Until very recently, before the introduction of the public smoking ban in Ireland, there was hardly any public debate about smoke-free environments in public places, in particular restaurants and bars (apart from a few comments on the outrageousness and/or ridiculousness of this smoker-hostile measure in America). Although the Irish example led to some media coverage and thus to some public discussion, the message from both the media and health politicians continued to be very "tolerant" towards smokers and critical towards EU legislation, thus consolidating existing public opinion rather than offering a new point of view. Only a few individuals, who are almost invisible among the majority of pro-smoking opinion leaders have been promoting non-smokers' rights or the need for smoke-free environments.

Consequently, Austrians have successfully developed a kind of 'fatalistic' approach, seeing smoking as something 'natural' and 'unavoidable', implying that banning smoking in public places would only lead to exclusion of smokers. The idea that three quarters of the population have been 'excluded' so far, is often brushed away with the 'natural' argument or that 'one could not help' this. It also implies that smoking is widely seen as something more or less 'harmless', though maybe a nuisance for others.

> *"People will always smoke, this is normal. You cannot forbid it."* (Frequent statement)

Interestingly, and thus confirming the successful socialisation of the Austrian public by the Austrian tobacco industry and their allies over decades, the Austrian media, very soon in the discussion the comparison with alcohol, a "much more dangerous drug", and environmental health hazards (such as exhaust gases from car traffic) is raised, while the dangers of smoking are played down. It is also common to compare tobacco with illegal drugs, in particular marijuana – if you forbid it, it would become more interesting and people would smoke even more.

> *"Every society has – and needs – its drug(s). In our culture, it is alcohol and cigarettes. At least these are less harmful than other drugs."* (Non-smoker, male)

> *"Then you would also have to forbid alcohol which certainly does much more harm to you and others. Look at the United States during Prohibition or at the Scandinavian countries where alcohol is forbidden – they really have a serious alcohol problem there. The same with hashish; it is forbidden but hardly any youth who never smoked it. It even becomes more attractive if it is forbidden."* (Occasional smoker, male)

Even teachers accept this 'powerless' view:

> *"If you forbid smoking to pupils, it becomes only more interesting and they would just smoke secretly in the toilet, and it would be even worse. You can't help that, you must give them a place where they can smoke."* (High-school teacher, non-smoker, female)

Especially when it comes to the discussion of smoke-free environments in restaurants and cafés or stricter regulations for the protection of non-smokers, the immediate reaction of many, including non-smokers or ex-smokers and even representatives from the field of public health policy, may be summarised as "pretended tolerance" (or even ignorance) – reducing the whole issue to an 'individual problem' of a few 'intolerant' or 'militant' non-smokers. This is an argument that recalls that of the 'happy slave' syndrome.

In Austria, tolerance has become the key word when it comes to smoking and alcohol (including the issue of drinking and driving, which is, compared to other countries, very mildly enforced), while Austrians are clearly less 'tolerant' when it comes to other subjects. Although apparently not known in Austria, even Italy, a country that is certainly more known for its individuality and tolerance, has successfully enforced advertising bans and smoke-free environments in many bars and restaurants. As in all other countries where legislation is pro-health and not pro-industry, there is public support for these measures. In Austria, tolerance would seem to be more an expression of an 'inferiority complex' of non-smokers who are repeatedly told they have no rights, whereas the right of smokers are continually stressed from all sides.

To illustrate the climate, a few examples of common statements that emerged in the process of information gathering are given here:

> *"Austria is a tolerant country." / "We Austrians are known to be tolerant"* (frequent statements)
>
> *"I am a non-smoker, but not a militant non-smoker."* (frequent statement)
>
> *"I am a non-smoker myself but I have never felt harassed by tobacco smoke. If I had, I would have to stay at home."* (Non-smoker, male)
>
> *"I am also a non-smoker but it never struck me that it stunk in bars or restaurants. All this is rather exaggerated."* (Representative of the Hospitality Association, male)
>
> *"I was a heavy smoker myself but I do not feel bothered when someone lights up a cigarette beside me."* (Ex-smoker, male)

However, one can also feel a potential for the offer of smoke-free environments:

> *"Well, of course I do feel bothered, but when I go out, everyone is smoking around me, and I have to accept it. Otherwise I would have to stay at home."* (Non-smoker, female)
>
> *"It is true, we do not go out frequently because you stink from head to toe, the clothes and everything, but you probably cannot forbid it – people want to smoke when they are out."* (Non-smoker, male)
>
> *"I often would like to go out for a drink or a coffee but when you come home you have to undress in the anteroom, put all clothes in the washing machine and take a shower and wash your hair, even if it is in the middle of the night. And if you complain you are very often looked at as someone who is just hysterical or over-sensitive or unsocial."* (Non-smoker, female)

Very often, smoking restrictions are related to prohibiting smoking completely and seen as something really drastic and outrageous, evoking fears of becoming a "police state".

> *"One cannot prohibit everything because then we will end up prohibiting coffee and tea as well. And history shows that it would only be worse, people would smoke even more and the black market would bloom. Besides, once you start this sort of thing you will end up as a police state."*

Another distinctive feature is the 'militarisation' of the issue of non-smokers' rights or smoke-free environments, particularly visible in the Austrian media, which refers to the danger of this

issue becoming a "battlefield" and a "military campaign" of (violent, intolerant, militant, aggressive) non-smokers against (poor, harassed, hunted down) smokers – ignoring the fact that until now non-smokers simply have had to endure smoky environments. As yet, nobody has used the term "militant smokers".

On the whole, smoking is regarded as a lifestyle factor and public health interventions relating to lifestyle choices are mostly seen as an intrusion into an individuals' most personal decisions. Health 'fascism', discrimination against smokers, and victim blaming are among the major themes of this discourse.[141] While experience in other countries has shown that 'no smoking' rules are largely self-enforcing, enhancing public support after their introduction, Austria's public opinion is still in full accordance with the tobacco industry which has been propagating for years that these kind of interventions would be construed as state intervention into private lives.

Even health politicians feel obliged to demonstrate their 'tolerance' and 'well-meaning' for the maintenance of a 'happy lifestyle'.

> *"We do not want to criminalise smokers. ... It must be step by step. The worst is this puritanism. ... One does not have to throw out the baby with the bath water."* (State Secretary of Health, cigar smoker, male)

> *"We do not want to rush things with any sort of enactments, which could be even disadvantageous to the actual behaviour... It is not our policy to condemn smokers and exert undue pressure... Finally, we are generally of the opinion that the point actually is to influence the lifestyle of Austrians positively and bring them happiness... Of course we do know that non-smoking contributes to an increase of the individual's lifespan of about 6 years on average, but of course we do not want to force the population now with over-rigorous laws and decrees to ... uh... er...[become abstinent? – sentence not completed]."* (Official from the Health Ministry, expert in tobacco control, male)

> *"I am not a missionary."* (Regional public health politician, ex-smoker, male)

As in many other European countries, the United States serves "as an all-purpose *bête noir*" in these polemics[141], used (in particular by the political left) as a "horrible example" of what might become of Austria once on this line.[141] [629] Developments in other European countries, such as Italy or the Scandinavian countries, are largely unknown in the population and thus ignored by politicians.

> *"Austrians are known to be very tolerant people. Outgrowths and conditions as in America or other intolerant countries where smokers are attacked do not exist here. This is why here not much happens, fortunately. The present situation and development in the EU with all these guidelines and regulations are ridiculous and exaggerated."* (Non-smoker, female)

> *"Well, of course it is sometimes a nuisance and a permanent temptation if you want to quit smoking, but on the other hand, if you look over to America, where people run around with their brown paper bags hiding their beer, and where smokers are treated like lepers, this is perverse. And once you start on this, there is a danger that it goes out of hand and before we realise it, we carry our brown bags and hide in a corner for a smoke."* (Male smoker who has been trying to quit smoking for many years)

> *"We do not want to become a second America."* (Official from the Ministry of Health working in health promotion and anti-smoking campaigns, smoker, male)

> *"One just has to look to America what happens there, you know, I really deem it to be rather excessive."* (Official from the Ministry of Health, expert in tobacco control, male)

> *"Recently I went again to the United States, and the bar, which was run normally last year, was empty this year. Of course, this is also a way of making social policy. But then I have*

> *to know that I am killing a whole entertainment business if one is no longer allowed to smoke in ANY bar."* (State Secretary of Health, cigar smoker, male)

Recently, emotions have also been directed towards 'Brussels' with these "ridiculous" and "anyway ineffective", "ugly" health warnings on cigarette packs, its plans to make Europe a second America, and patronising people with regard to their 'personal freedom' and 'individual responsibility'. Now having a 'common enemy' (successfully created and magnified by the media and even by health politicians), who wants to 'dictate' to us 'tolerant' and 'self-determined' Austrians what to do and who offers itself as the one to whom one has to offer resistance, the attitude of Austrians towards any kind of 'enforced' smoking restrictions may be described as rather immature. One expression of this 'boycott' seems to be the success of various sheaths to cover "ugly areas" on "your" cigarette packet (particularly addressed at young people) – as phrased, for example, in the following advertisement of a mail order company:

> "Cigarette sheath as business card. Advantages: Covers ugly areas on your cigarette pack. ... You demonstrate that you don't let yourself be patronised, least of all from the EU Health Ministers."

It seems, however, that, perhaps following the discussion on the Irish smoking ban, at least among some individuals an increased awareness is now beginning to emerge.

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